

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) FRANK			First Clayton Middle ALLEN Last			2a. DATE OF DEATH Month 11 Day 1 Year 68		2b. HOUR 12:05 MIN.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-3-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS 28 HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Keyser W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.			13b. COUNTY MINERAL		13c. CITY OR TOWN KEYSER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 201 FORT AVE.,	
14. FATHER'S NAME First JOHN Middle H. Last ALLEN			15. MOTHER'S MAIDEN NAME First MARGARET Middle C. Last BLAMBLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 705-05-8079		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Mrs. Elizabeth B. Allen - Keyser, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 550X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) secondary to right inguinal DUE TO, OR AS A CONSEQUENCE OF (c) herniorrhaphy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5600										
19a. DATE OF OPERATION 10-23-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right inguinal hernia			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10-21- , 1968 , to 11-1- , 1968 , that (I) (we) last saw the deceased alive on 10-31- , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Earl R. Paul				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-4-68 MD.				
22d. PHYSICIAN'S NAME (Type) DR. EARL R. PAUL				22e. ADDRESS 414 N. MECHANIC ST., CUMBERLAND.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-4-68		23c. NAME OF CEMETERY OR CREMATORY Potomac V.M. Park		23d. LOCATION (City or Town) (County) (State) Keyser, W. Va. Mineral				
24. FUNERAL DIRECTOR Harold W. McKoy				ADDRESS Keyser, W. Va.		25a. REC'D BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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U. S. A. WHITE 1-3-1982 ALLEGANY

MEMORIAL HOSP. 1201 FORT AVE.

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Item Film 407 12/3/68 kb

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15232

15221

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Helen C. Altice			2a. DATE OF DEATH Month Nov. Day 20 Year 68			2b. HOUR 757 P	
3. SEX Female		4. RACE American White		5. DATE OF BIRTH 8-13-06		6. AGE (In years last birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Va		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center (R.N.)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1105 Michigan Ave.		14. FATHER'S NAME First Middle Last Arthur Stull		15. MOTHER'S MAIDEN NAME First Middle Last Catherine T. Mc Gady		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. 234-60-3487		17. INFORMANT Address Frank Altice Husband. Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastatic 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Bladder DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sev. Years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1810							
19a. DATE OF OPERATION 11/21/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder Resection		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Colony			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1968 , to 20 , 19 Nov , that (I) (we) last saw the deceased alive on Oct , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carlton Brinsfield MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 23, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. Carlton Brinsfield, MD		22e. ADDRESS Decatur St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR Funeral Scarpelli Home		ADDRESS 108 Virginia Ave.		25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE John Judge	

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RECEIVED

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<div style="display: flex; justify-content: space-between;"> 15228 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15233 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>																	
1. DECEASED NAME (Type or print)			First JOHN			Middle CALVIN			Last BAKER			2a. DATE OF DEATH Nov Month 12 19 68			2b. HOUR 2:05 PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JUNE 21, 1902			6. AGE (In years last birthday) 66 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) FAIRHOPE PA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.					
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during normal working life) RETIRED CAPTAIN B&O RAILROAD			12b. KIND OF BUSINESS OR								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 643 HENDERSON AVE.					
14. FATHER'S NAME First Middle Last CHARLES BAKER			15. MOTHER'S MAIDEN NAME First Middle Last EMMA FLICKINGER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 705-09-9013			17. INFORMANT Address MRS GERALDINE BAKER 643 HENDERSON AVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) A CVD. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days - years -																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 10/29 , 19 68 , to 11/12 , 19 68 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE John B. Davis			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11/14/68								
22d. PHYSICIAN'S NAME (Type) John B Davis			22e. ADDRESS 2 Broadway, Frostburg Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE NOV 15, 1968			23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) LAVALLE ALLEGANY MD.								
24. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL HOME			ADDRESS 404 DECATUR ST. CUMBERLAND, MD.			25a. REC'D BY REGISTRAR DATE NOV 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

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VR A15 (11)
30M REV. 1-68

MARYLAND, STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
15226		15234										
1. DECEASED-NAME (Type or print) First Middle Last Raymond A. Berry						2a. DATE OF DEATH Month Day Year 11 4 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12/31/07			6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.						
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian Public School			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.			13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Albert Berry				15. MOTHER'S MAIDEN NAME First Middle Last Anna Emmart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Millicent Berry, Midland, Md. (WIFE)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 7 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute hepatitis - Duodenitis - Duodenal ulcer												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not while at work <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 19 62 to Nov. 4, 1968, that (I) (we) last saw the deceased alive on Nov. 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE L.R. Miles MD DEGREE								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-4-68		
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.								22e. ADDRESS LONA CONING MD 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/6/1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.				25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15226										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15235									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
EUGENE BERNARD BIRMINGHAM										Month November Day 30 Year 1968										4:45 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			WHITE			02-25-02			66 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
MARYLAND			USA						ALLEGANY Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
CUMBERLAND					SACRED HEART HSOP.					Inspector, Ret.					BREWERY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					ALLEGANY					CUMBERLAND					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					Henderson Ave. ROOM 8, YORK HOTEL									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
WILLIAM BIRMINGHAM					JENKINS LILLIAN Estella BIRMINGHAM																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
NO					220-07-6603					HOSPITAL RECORD, SETON DRIVE, CUMB., MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>congestive heart failure</u>															1 month														
4129 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) <u>coronary artery disease</u>															2 years														
DUE TO, OR AS A CONSEQUENCE OF																													
(c) <u>arteriosclerosis</u>															6 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
4201																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6-</u> 19 <u>68</u> , to <u>11-30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-29</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Lewis Brings</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>11-30-68</u>														
22d. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.										22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12/2/68					St. Patrick's Cemetery					Cumberland, Allegany Md.														
24. FUNERAL DIRECTOR <u>H. Wayne George</u>										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
GEORGE FUNERAL HOME -202 GREENE -CUMB., MD.															DATE <u>DEC 3 1968</u>					<u>James H. Judge</u>									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15225

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15236

1. DECEASED-NAME (Type or Print) First Middle Last John G Blank			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year NOV. 27, 1968			2b. HOUR 6:45 PM			
3. SEX M	4. RACE White	5. DATE OF BIRTH Jan. 27, 1885	6. AGE (in years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year NOVEMBER 27, 1968			2d. HOUR 6:45 P M
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL-DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if in institution: Residence before admission) STATE Pa.			13b. COUNTY Somerset		13c. CITY OR TOWN Wellersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Lewis Blank			15. MOTHER'S MAIDEN NAME First Middle Last Mary Snyder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Sacred Heart Hospital, Cumberland Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8147 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) (STRUCK BY VEHICLE) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 8129									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 6:15 P.M. Nov. 27 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Struck by Vehicle (Pedestrian)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State Near Wellersburg, Pa. Somerset, Pennsylvania				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED November 27, 1968			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/30/68		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Savage Allegany Md			
24. FUNERAL DIRECTOR Harvey H. Zeigler			ADDRESS Hyndman, Pa.			25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15226

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15237

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
Alexander						BOYD		Nov, 19, 1968		11		19		1968		1:35	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	1/2/1902		66 YRS.		MONTHS		DAYS		Nov, 19, 1968		11		19		1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH				Md.	
MD.		USA.										Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Sacred Heart Hospital		Retired, Celanese Corp.													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
MD.		Allegany		LaVale		YES <input type="checkbox"/> NO <input type="checkbox"/>		5 Oaklawn Ave.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
ALEXANDER						BOYD		AGNES						POLLOCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No				Mrs. Marie Eichler Kackensach, N.J.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DIABETIC COMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		6 Hours							
2509		DUE TO, OR AS A CONSEQUENCE OF		(DIABETES)		Years											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)		260x															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)													
		HOUR A.M.		P.M.		19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		November 19, 1968											
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND			
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		11/22/68		Oak Hill Cemetery		Lonaconing		A.		Md							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
GEORGE EICHHORN		Lonaconing, Md.		NOV 21 1968		Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE												
1. DECEASED NAME (Type or print) EAST BUCKEL, FIRST REX					2a. DATE OF DEATH Month 11 Day 21 Year 68					2b. HOUR 9:29 PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 02-09-09			6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS 59 DAYS 59 HOURS 59 MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY FARMING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY Garrett			13c. CITY OR TOWN BITTINGER			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER BITTINGER, MD. 21522			
14. FATHER'S NAME First OLIVER Middle BUCKEL Last BUCKEL			15. MOTHER'S MAIDEN NAME First (SHOUP) Middle RUTH Last BUCKEL			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 219-01-6254			
17. INFORMANT Address MD. 21502			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE, RECENT, OLD 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11-21-68 , 19 68 , to 11-21-68 , 19 68 , that (I) (we) last saw the deceased alive on 11-21-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE M. Kauffman			22c. DATE SIGNED 11-21-68			22d. PHYSICIAN'S NAME (Type) M. KAUFFMAN, M.D.			22e. ADDRESS 912 SETON DR., CUMB., MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/25/68			23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery			23d. LOCATION (City or Town) (County) (State) Bittinger, Garrett, Md.			
24. FUNERAL DIRECTOR Ruth Newman			25a. REC'D BY REGISTRAR NOV 25 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						
NEWMAN FUNERAL HOME, GRANTSVILLE, MD.												

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ALLEGANY COUNTY

CUMBERLAND

COCKED HEART HOSPITAL

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LARRYMAN

DITTINGER

DITTINGER, RD. 21222

OLIVER

BUCKEL

(SHUP)

RUTH

BUCKEL

RD. 21202

SACKED HEART HOSPITAL, 800 SETON DR., C.

NEW AN FUNERAL HOME, GRANTVILLE, MD.

W. KUFFMAN, I.

812 SETON DR., CU D., I. 21202

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15228

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15239

1. DECEASED-NAME (Type or print) EVA		First M. Middle BURKET Last		2a. DATE OF DEATH NOVEMBER 10 Day 68 Year		2b. HOUR 9:00AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/8/98		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY CO., Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACKED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNSYLVANIA		13c. CITY OR TOWN EVERETT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1106 N. SPRING ST.	
14. FATHER'S NAME First ALEX Middle CARTWRIGHT Last		15. MOTHER'S MAIDEN NAME First MARY Middle DARR Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 211 40 2071		17. INFORMANT PATIENTS HOSPITAL CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS, KIMMELSTIEL-WILSON SYNDROME, DEPRESSIVE REACTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-16 , 19 68 , to 11-10 , 19 68 , that (I) (we) last saw the deceased alive on 11-10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leola W. Ballin		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/10/68			
22d. PHYSICIAN'S NAME (Type) DR. R. W. BALLIN		22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/12/68		23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		23d. LOCATION (City or Town) (County) (State) Everett, Bedford Co., Pa.	
24. FUNERAL DIRECTOR Lynford V. Conner		ADDRESS Everett, Pa.		25a. REC'D BY REGISTRAR NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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ALLEGANY CO., X PENNSYLVANIA UNITED STATES

NONE NONE SACRED HEART HOSP. CO. BERLIND, MO.

1100 N. SPRING ST. X EVERETT PENNSYLVANIA

CURR. CATH/RIGHT BRY CARTRIGHT

NO. 211 NO. 2071 PATIENTS HOSPITAL CHART

1 WEEK LEFT VENTRICULAR FAILURE

1 YEAR AFTER ISCHEMOTIC CARDIOVASCULAR DISEASE

DIABETES MELLITUS, KIMBLETT-ILSON SYNDROME, DEPRESSIVE REACTION

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DR. R. M. BOLLIN 63 GREENE ST., CUMMELAND, MO. 2103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ROY			First ROY Middle F. Last CHILDRESS			2a. DATE OF DEATH Month 11 Day 14 Year 68			2b. HOUR 9 MIN 50 AM P		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 02-12-03			6. AGE (In years lost birthday) 65 YRS.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SHOE CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY SHOE REPAIR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 615 ELM STREET			14. FATHER'S NAME First JOHN Middle CHILDRESS Last CHILDRESS			15. MOTHER'S MAIDEN NAME First (DENA) Middle HALLEY Last CHILDRESS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, NO (known) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 226-03-6517			17. INFORMANT Address MD. 21502			17. INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,			17. INFORMANT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of pelvis, probable DUE TO, OR AS A CONSEQUENCE OF (c) fracture										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 177X											
19a. DATE OF OPERATION 10-18-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pelvic mass			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-3 , 19 68 , to 11-14 , 19 68 , that (I) (we) last saw the deceased alive on 11-14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mees			22c. DATE SIGNED 11-18-68			22d. PHYSICIAN'S NAME (Type) J.L. VALDES, M.D.			22e. ADDRESS ALGONQUIN HOTEL, CUMB., MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Nov. 17, 1968			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME-108 VIRGINIA AVE., CUMB.			25a. REC'D BY REGISTRAR DATE NOV 22 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

SCARBELL FUNERAL HOME-108 VIRGINIA AVE., CUMBERLAND, MD.

Nov. 17, 1962 Sunset Memorial Park

Cumberland, Md.

J. L. WILDES, M.D.

CLONUM HOTEL, CUMBERLAND, MD. 21502

NO

226-02-6517 SACRED HEART HOSPITAL, 600 SETON DR., CUMBERLAND, MD. 21502

JOHN

CHILDRESS (DEAN) HALEY

CHILDRESS

LARRYLAND

ALLEGANY CUMBERLAND

X

615 ELL STREET

CUMBERLAND

SACRED HEART HOSPITAL

SHOE CARPENTER

SHOE REPAIR

VIRGINIA

U.S.A.

X

ALLEGANY COUNTY,

DATE

WHITE

02-12-03

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F.

CHILDRESS

11

11

66, 0'50

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
Charles Willis Conway						Nov. 2 68			11A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	May 27, 1897	71					Nov. 2 68			11A M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Penna.			USA						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial H.			Retired Machinist			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Allegany			Cumberland			244 N. Centre St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Kimmel Conway			Catherine Hiett								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
yes			War I			Mrs. Clara Conway, Cumberland, Md.-Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Sudden *****										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>4201</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Nov. 2, 1968		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			Rt. 9, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Nov. 5, 1968		Sunset Memorial Park			Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						NOV 6 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First ELIZABETH		Middle M.		Last COOPER		2a. DATE OF DEATH Month Day Year NOVEMBER 20, 1968		2b. HOUR 1:50 M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 5, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN OLDTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. #1		
14. FATHER'S NAME First Middle Last CHARLES S. NAILL		15. MOTHER'S MAIDEN NAME First Middle Last DAISY M. GRIMES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hernia</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> 443X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>68</u> , to <u>11-20</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>11/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William S. James</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/20/68				
22d. PHYSICIAN'S NAME (Type) DR. W. JAMES		22e. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE nov. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Oldtown Cem.		23d. LOCATION (City or Town) (County) (State) Oldtown (Allegany) Md.				
24. FUNERAL DIRECTOR Johnson Funeral Home, Berkeley Springs 106 Wilkes Street		ADDRESS W. Va.		25a. REC'D BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

10000

10000

DATE OF BIRTH

ELIZABETH M.

COOPER

NOVEMBER 30, 1900 1:30

FEMALE

WHITE

AUGUST

1900

RECORD

U.S.A.

VILLAGE

GENERAL HOSPITAL

ALL A. T. OLTOW

X RT. 21

CHARLES S.

JAMES

DAISY

1903

GENERAL HOSPITAL, CHICAGO, ILL.

DR. W. JAMES

DR. W. JAMES

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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<div>15232</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>												<div>15243</div>	
1. DECEASED-NAME (Type or Print) GWENDOLYN D. DAVIS						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year NOV. 29, '68			2b. TIME OF DEATH 11:05 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 19, 1920		6. AGE (in years last birthday) 48 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>			
7a. BIRTHPLACE (State or foreign country) W. Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Coning Dept.			12b. KIND OF BUSINESS OR INDUSTRY Amcelle Co, Textile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. COUNTY Allegany		13c. CITY OR TOWN Rawlings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME Robert L. Davis						15. MOTHER'S MAIDEN NAME Bertha Luzier							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. 219-14-7280		17. INFORMANT Joseph M. James				ADDRESS Rt #3, Rawlings, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) THORACIC & ABDOMINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) FRACTURED RIBS, FRACTURED PELVIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 8129													
19a. DATE OF OPERATION 11-29-68						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Pedestrian Struck by Vehicle				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 11:05 P.M.						21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11-29-68 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pedestrian Struck by Vehicle					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Route # 220						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Near Celanese Plant, Cumberland, Alleg. Md.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED November 29, 1968					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or village) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Dawson Cemetery				23d. LOCATION (City or Town) (County) (State) Rt #3, Rawlings, Md					
24. FUNERAL DIRECTOR Allen M. Rotruck, Keyser, WVE						ADDRESS		25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15233

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15244

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) BESSIE		First Chadwick		Middle DUCKWORTH		Last		2a. DATE OF DEATH Month 11 - Day 24 - Year 68			2b. HOUR P 10:57M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 01-25-87			6. AGE (In years last birthday) 81 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hostess & HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY Private club				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Meadow Dr. RT. #5, BOX 213, CRESAPTOWN				
14. FATHER'S NAME First BENJAMIN		Middle NICHOLS		Last		15. MOTHER'S MAIDEN NAME First (MC GEE) SARAH		Middle --		Last McGee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-05-5284		17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) ARTERIOSCLEROTIC AND CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 5 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) PERIPHERAL VASCULAR DISEASE, AMPUTATION RIGHT LEG, GANGRENE												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 11 Day 24 Year 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 10 - 6 City or Town 1958 County 11 - 24 State 1968								
22a. I certify that (I) (this hospital) attended the deceased from 10 - 6 , 19 58 , to 11 - 24 , 19 68 , that (I) (we) last saw the deceased alive on 11 - 24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Rw Ball M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11 - 25 - 68		
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22e. ADDRESS 62 GREENE ST., CUMB., MD. 21502										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD.		25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge						

12833

P

11-27-57 10:27 AM DESSIE

WHITE 01-25-57 81

MARYLAND 8.1.1 ALLEGANY COUNTY

CONFERRED SACKED HEART HOSPITAL

MARYLAND ALLEGANY CRESSAPTON MT. 25, BOX 212, CRESSAPTON

21-03-55 (10 CEE) SACKED HEART HOSPITAL, 200 SETON DR., CORP.,

CONGESTIVE HEART FAILURE 2 WEEKS

2 WEEKS 2 WEEKS

2 WEEKS 2 WEEKS

PERIPHERAL VASCULAR DISEASE, AMPUTATION RIGHT LEG, ANGIOPLASTY

X

11-27-57 10-8-57 11-27-57

X

R.M. BOLLIN, 1.0.1 25 GREENE ST., CORP., MT. 21502

GEORGE FUNERAL HOME, 203 GREENE ST., CORP., MT. 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15234										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15245																																							
1. DECEASED-NAME (Type or print)										First MARY Middle T. Last DUNKLE										2a. DATE OF DEATH NOV. Month 7 Day 1968 Year										2b. HOUR M																													
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH MARCH 26, 1886										6. AGE (In years last birthday) 82 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY Md.																													
10. CITY OR TOWN OF DEATH FROSTBURG										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 20 LOCUST STREET										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN FROSTBURG										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 20 LOCUST STREET																			
14. FATHER'S NAME First WALTON Middle E. Last TAYLOR										15. MOTHER'S MAIDEN NAME First MOLLIE Middle KING Last																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 213-48-3873										17. INFORMANT JOHN L. DUNKLE, FROSTBURG, MD. 21532										Address																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Metastatic Carcinomatosis of Esophagus										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo.																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 150x Hypertensive Arteriosclerotic CVD.																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input checked="" type="checkbox"/> (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 6-8-68, 1968, to NOV. 7, 1968, that (I) (we) lost sow the deceased alive on 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Martin Rothstein										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 11-7-68																																							
22d. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.										22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 11-9-68										23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY										23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.																													
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532										ADDRESS										25a. REC'D BY REGISTRAR DATE NOV 12 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15235		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15246	
Item#5, FilmG406 11/22/68 km		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First NAN		Middle G		Last ENGLE	
2a. DATE OF DEATH		Month 11		Day 13		Year 68	
2b. HOUR		2:20PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1-12-86/ 1887		6. AGE (In years lost birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give nearest hospital) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY ✓		13c. CITY OR TOWN MEYERSDALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER NORTH ST.		14. FATHER'S NAME First SIMON		Middle LIVENGOOD		Last KRAMER	
15. MOTHER'S MAIDEN NAME First ARMINTA		Middle KRAMER		Last KRAMER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 175-30-4845		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE, GENERALIZED</u> 201X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 YRS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 201X NO							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>63</u> , to <u>Nov</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Nov 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John P. Light, MD</u>		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/14/68	
22d. PHYSICIAN'S NAME (Type) DR. JOHN P. LIGHT		22e. ADDRESS CUMBERLAND, MD.		22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/17/68		23c. NAME OF CEMETERY OR CREMATORY St Paul Cemetery		23d. LOCATION (City or Town) (County) (State) RD 1 Meyersdale Som, Pa.	
24. FUNERAL DIRECTOR <u>M.R. Leckemf</u> Price Funeral Home		ADDRESS 325 Main Street Meyersdale, Pa.		25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12233

19-08-2009 11:11 AM

1-12-2008

ALLISON

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

LIVERPOOL

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

LIVERPOOL

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

LIVERPOOL

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

LIVERPOOL

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

LIVERPOOL

GENERAL HOSPITAL

MEYERDALE & NORTH ST.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15236

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15247

1. DECEASED-NAME (Type or Print) A Dayton Eversole			2a. DATE KNOWN OF DEATH Month 11 Day 14 Year 1968 07 PM			2b. HOUR				
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 2, 1895	6. AGE (in years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 73	IF UNDER 24 HRS. DAYS 73	IF UNDER 24 HRS. HOURS 73	IF UNDER 24 HRS. MIN. 73	2c. DATE PRONOUNCED DEAD Month 11 Day 14 Year 1968 07 PM	2d. HOUR	
7a. BIRTHPLACE (State or foreign country) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Employee- B & O R.R.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 866 Maryland Avenue
14. FATHER'S NAME First Alexander Middle B Last Eversole			15. MOTHER'S MAIDEN NAME First Mary Middle Compton Last Compton			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 217-10-5661	17. INFORMANT Mrs. Ruth Eversole
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS (c) CORONARY OCCLUSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201				
19a. DATE OF OPERATION 4201			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED November 14, 1968	
EXAMINER'S NAME (Type) Benedict Skitarelic, m.d.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cumberland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/17/68			23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery			23d. LOCATION (City or Town) (County) (State) Fort Ashby Mineral W. Va	
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service			ADDRESS Cumberland, Md			25a. REC'D BY REGISTRAR NOV 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	

2002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
15237																							
15248																							
1. DECEASED-NAME (Type or print)			First HORACE			Middle E.			Last FISHER			2a. DATE OF DEATH Month NOVEMBER			Day 12			Year 1968			2b. HOUR A 15		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH SEPTEMBER 9, 1886			6. AGE (In years lost birthday) 82			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) ELLIOTT CITY, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY														
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during most of working life, even if retired.) MEMORIAL HOSPITAL, CUMB., MD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY QUEEN CITY DAIRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FLINTSTONE			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER STAR ROUTE											
14. FATHER'S NAME First CHRISTOPHER			Middle FISHER			Last FISHER			15. MOTHER'S MAIDEN NAME First CLARISSA			Middle UNKNOWN			Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-4545			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>on basis of Arterio Sclerotic C.V. Dis. Feb. '50</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4321 <u>Myeloid Leukemia</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since</u>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State								
22a. I certify that (I) (this hospital) attended the deceased from <u>2-21-1956</u> , to <u>11-12-1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11-11-1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.																							
22b. SIGNATURE <u>W.F. Williams</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																		22c. DATE SIGNED <u>11-12-68</u>					
22d. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS																		22e. ADDRESS 122 SO. CENTRE STREET, CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov 15, 1968			23c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cemetery			23d. LOCATION (City or Town) Near Artemas			(County) Bedford			(State) Penna								
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>			ADDRESS 230 Balto Ave. Cumberland			25a. REC'D BY REGISTRAR MD NOV 14 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														

10000

GRACE

E.

FISHER

SEPTEMBER 12, 1900

WHITE

MALE

ELLIOTT CITY, MD.

ALLIANCE

MEMORIAL HOSPITAL, CONN.

MARYLAND

CHRISTOPHER

FISHER

MARYLAND

MARYLAND

MARYLAND

MARYLAND

122 ST. CENTRE STREET, CONN.

DR. WILLIAMS

Nov 15, 1900

Nov 14, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) JOHN			First JOHN			Middle W.			Last FOGLE			2a. DATE OF DEATH Month 11 Day 29 Year 68			2b. HOUR 3:00 P.M.				
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 1-17-1890			6. AGE (In years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.										
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and no.) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 222 PIEDMONT AVE.,							
14. FATHER'S NAME First FOGLE			Middle FOGLE			Last FOGLE			15. MOTHER'S MAIDEN NAME First EDIZABETH			Middle MC CLELLAN			Last MC CLELLAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure due to 493X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days you																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 241X																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 11/15/68 , to 11/29/68 , that (I) (we) last saw the deceased alive on 11/15/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Blane Schindler			DEGREE DR. BLANE SCHINDLER			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11/30/68										
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER			22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.																
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/12/68			23c. NAME OF CEMETERY OR CREMATORY SUNSET Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md										
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 3 1968			25b. REGISTRAR'S SIGNATURE Charles Judge										

18838

JOHN

W.

FOGLE

11 10 08 P.M.

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1-17-1890

70

MARYLAND

U. S. A.

X

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

MARYLAND

ALLEGANY CUMBERLAND X

322 PIEDMONT AVE.

FOGLE

ELIZABETH

MC CLELLAN

MEMORIAL HOSPITAL-CUMBERLAND, MD.

DR. BLANE SCHINDLER

43 GREENE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15239

15250

1. DECEASED-NAME (Type or print)		First ELNIRA	Middle H.	Last FRANKENBERRY	2a. DATE OF DEATH Month NOVEMBER Day 25 Year 1968		2b. HOUR 3:10 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 20, 1919		6. AGE (In years lost birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) FREEPORT, PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Self			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. #1, BOX 200	
14. FATHER'S NAME First Middle Last ROBERT C. HAINES		15. MOTHER'S MAIDEN NAME First Middle Last LENA CLARK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 213-22-3565		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Common Brounchectasis</i> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 20, 1919</i> to <i>Nov 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 24, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. Schindler</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11/25/68</i>			
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md			
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>		ADDRESS 230 Balto Ave. Cumberland Md		25a. REC'D BY REGISTRAR NOV 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

10000

MINUTE OF THE

1930

EMIRA H. FRANKENBERRY NOVEMBER 25, 1930



LEWIS	WHITE	JANUARY 20, 1919	ALL-ARMY
FREEPORT, P.R.	U.S.A.		
CUMBERLAND, MD.	MEMORIAL HOSPITAL		
ALL-ARMY	PI. SAVAGE	X	PI. 1, BOX 200
ROBERT	C. JAINES	LEIA	CLARK
			MEMORIAL HOSPITAL, CUMBERLAND, MD.

Blank lines for additional entries.

DR. B. SCHWOLFER
A. GREENE ST., CUMBERLAND, MD.
Memorial Hospital, Cumberland, Md.
120 White Ave., Cumberland, Md.

15240

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) KATHRYN First P Middle GILL Last			2a. DATE OF DEATH Month 11 Day 9 Year 68			2b. HOUR 12:50A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2-9-1918		6. AGE (In years lost birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full name) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 481 BALTIMORE AVE.,							
14. FATHER'S NAME First OWEN Middle Last KEEGAN			15. MOTHER'S MAIDEN NAME First BERTHA Middle Last RODERICK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident - Cerebral Hemorrhage 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4301 (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis - Myocardial Fibrosis 1959 1962							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sep. 7, 1962 , to Nov. 9, 1968 , that (I) (we) last saw the deceased alive on Nov. 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 						22c. DATE SIGNED 11/9/68	
22d. PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/11/68		23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.				25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First JAMES			Middle E.			Last GORDON			2a. DATE OF DEATH Month 11 Day 23 Year 68			2b. HOUR 2:15 P.M.		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 1-5-1893			6. AGE (In years lost birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Painter			12b. KIND OF BUSINESS OR INDUSTRY Allegany Co.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 611 COLUMBIA AVE.,					
14. FATHER'S NAME First HENRY			Middle I.			Last GORDON			15. MOTHER'S MAIDEN NAME First LUCINDA			Middle MEARKLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes			16b. SOCIAL SECURITY NO. 214-07-4821			17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strengthened by CVD - Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 416X - Severe atherosclerosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week many years					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street, or R.F.D. No. City or Town County State Cumberland Allegany Md											
22a. I certify that (I) (this hospital) attended the deceased from 4/23/65 , 19 65 , to 4/23/68 , 19 68 , that (I) (we) last saw the deceased alive on 4/23/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE DR. R. J. WILLIAMS						22c. DATE SIGNED 11/25/68			22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS								
22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, or other disposition (Specify)			23b. DATE 11/26/1968			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md								
24. FUNERAL DIRECTOR Charles E. Hafer ADDRESS Charles E. Hafer, 230 Balto Ave., Cumberland						25a. REC'D BY REGISTRAR NOV 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

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ALLIANCE

CUMBERLAND

RECORDED

2000, 1999, 1998, 1997, 1996, 1995, 1994, 1993, 1992, 1991, 1990, 1989, 1988, 1987, 1986, 1985, 1984, 1983, 1982, 1981, 1980, 1979, 1978, 1977, 1976, 1975, 1974, 1973, 1972, 1971, 1970, 1969, 1968, 1967, 1966, 1965, 1964, 1963, 1962, 1961, 1960, 1959, 1958, 1957, 1956, 1955, 1954, 1953, 1952, 1951, 1950, 1949, 1948, 1947, 1946, 1945, 1944, 1943, 1942, 1941, 1940, 1939, 1938, 1937, 1936, 1935, 1934, 1933, 1932, 1931, 1930, 1929, 1928, 1927, 1926, 1925, 1924, 1923, 1922, 1921, 1920, 1919, 1918, 1917, 1916, 1915, 1914, 1913, 1912, 1911, 1910, 1909, 1908, 1907, 1906, 1905, 1904, 1903, 1902, 1901, 1900, 1899, 1898, 1897, 1896, 1895, 1894, 1893, 1892, 1891, 1890, 1889, 1888, 1887, 1886, 1885, 1884, 1883, 1882, 1881, 1880, 1879, 1878, 1877, 1876, 1875, 1874, 1873, 1872, 1871, 1870, 1869, 1868, 1867, 1866, 1865, 1864, 1863, 1862, 1861, 1860, 1859, 1858, 1857, 1856, 1855, 1854, 1853, 1852, 1851, 1850, 1849, 1848, 1847, 1846, 1845, 1844, 1843, 1842, 1841, 1840, 1839, 1838, 1837, 1836, 1835, 1834, 1833, 1832, 1831, 1830, 1829, 1828, 1827, 1826, 1825, 1824, 1823, 1822, 1821, 1820, 1819, 1818, 1817, 1816, 1815, 1814, 1813, 1812, 1811, 1810, 1809, 1808, 1807, 1806, 1805, 1804, 1803, 1802, 1801, 1800, 1799, 1798, 1797, 1796, 1795, 1794, 1793, 1792, 1791, 1790, 1789, 1788, 1787, 1786, 1785, 1784, 1783, 1782, 1781, 1780, 1779, 1778, 1777, 1776, 1775, 1774, 1773, 1772, 1771, 1770, 1769, 1768, 1767, 1766, 1765, 1764, 1763, 1762, 1761, 1760, 1759, 1758, 1757, 1756, 1755, 1754, 1753, 1752, 1751, 1750, 1749, 1748, 1747, 1746, 1745, 1744, 1743, 1742, 1741, 1740, 1739, 1738, 1737, 1736, 1735, 1734, 1733, 1732, 1731, 1730, 1729, 1728, 1727, 1726, 1725, 1724, 1723, 1722, 1721, 1720, 1719, 1718, 1717, 1716, 1715, 1714, 1713, 1712, 1711, 1710, 1709, 1708, 1707, 1706, 1705, 1704, 1703, 1702, 1701, 1700, 1699, 1698, 1697, 1696, 1695, 1694, 1693, 1692, 1691, 1690, 1689, 1688, 1687, 1686, 1685, 1684, 1683, 1682, 1681, 1680, 1679, 1678, 1677, 1676, 1675, 1674, 1673, 1672, 1671, 1670, 1669, 1668, 1667, 1666, 1665, 1664, 1663, 1662, 1661, 1660, 1659, 1658, 1657, 1656, 1655, 1654, 1653, 1652, 1651, 1650, 1649, 1648, 1647, 1646, 1645, 1644, 1643, 1642, 1641, 1640, 1639, 1638, 1637, 1636, 1635, 1634, 1633, 1632, 1631, 1630, 1629, 1628, 1627, 1626, 1625, 1624, 1623, 1622, 1621, 1620, 1619, 1618, 1617, 1616, 1615, 1614, 1613, 1612, 1611, 1610, 1609, 1608, 1607, 1606, 1605, 1604, 1603, 1602, 1601, 1600, 1599, 1598, 1597, 1596, 1595, 1594, 1593, 1592, 1591, 1590, 1589, 1588, 1587, 1586, 1585, 1584, 1583, 1582, 1581, 1580, 1579, 1578, 1577, 1576, 1575, 1574, 1573, 1572, 1571, 1570, 1569, 1568, 1567, 1566, 1565, 1564, 1563, 1562, 1561, 1560, 1559, 1558, 1557, 1556, 1555, 1554, 1553, 1552, 1551, 1550, 1549, 1548, 1547, 1546, 1545, 1544, 1543, 1542, 1541, 1540, 1539, 1538, 1537, 1536, 1535, 1534, 1533, 1532, 1531, 1530, 1529, 1528, 1527, 1526, 1525, 1524, 1523, 1522, 1521, 1520, 1519, 1518, 1517, 1516, 1515, 1514, 1513, 1512, 1511, 1510, 1509, 1508, 1507, 1506, 1505, 1504, 1503, 1502, 1501, 1500, 1499, 1498, 1497, 1496, 1495, 1494, 1493, 1492, 1491, 1490, 1489, 1488, 1487, 1486, 1485, 1484, 1483, 1482, 1481, 1480, 1479, 1478, 1477, 1476, 1475, 1474, 1473, 1472, 1471, 1470, 1469, 1468, 1467, 1466, 1465, 1464, 1463, 1462, 1461, 1460, 1459, 1458, 1457, 1456, 1455, 1454, 1453, 1452, 1451, 1450, 1449, 1448, 1447, 1446, 1445, 1444, 1443, 1442, 1441, 1440, 1439, 1438, 1437, 1436, 1435, 1434, 1433, 1432, 1431, 1430, 1429, 1428, 1427, 1426, 1425, 1424, 1423, 1422, 1421, 1420, 1419, 1418, 1417, 1416, 1415, 1414, 1413, 1412, 1411, 1410, 1409, 1408, 1407, 1406, 1405, 1404, 1403, 1402, 1401, 1400, 1399, 1398, 1397, 1396, 1395, 1394, 1393, 1392, 1391, 1390, 1389, 1388, 1387, 1386, 1385, 1384, 1383, 1382, 1381, 1380, 1379, 1378, 1377, 1376, 1375, 1374, 1373, 1372, 1371, 1370, 1369, 1368, 1367, 1366, 1365, 1364, 1363, 1362, 1361, 1360, 1359, 1358, 1357, 1356, 1355, 1354, 1353, 1352, 1351, 1350, 1349, 1348, 1347, 1346, 1345, 1344, 1343, 1342, 1341, 1340, 1339, 1338, 1337, 1336, 1335, 1334, 1333, 1332, 1331, 1330, 1329, 1328, 1327, 1326, 1325, 1324, 1323, 1322, 1321, 1320, 1319, 13

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NEWBORN HOSPITAL - CONVENTLAND, MD.

CHALLENGE 6.8.30

155 2. CENTRE ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be excluded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 15248 CERTIFICATE OF DEATH 15253 </div> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div>											
1. DECEASED-NAME (Type or print)			First Middle Last KATIE Katherine M. Margaret HARVEY			2a. DATE OF DEATH NOVEMBER 17, 1968			2b. RM 5:50 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8-31-01-8-31-01			6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of last year or retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 211 RACE ST.		
14. FATHER'S NAME First Middle Last WILLIAM MCINTURFF			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET LeCount LAKEHOUSE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Angina Pectoris										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 5 yrs 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 17, 1960 , to Nov. 17, 1968 , that (I) (we) lost the deceased on Nov. 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Clay Durrett DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED Nov. 18, 1968			
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT								22e. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE Nov. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE NOV 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1554

1553

NOVEMBER 17, 1968:50

6-21-04-21-01 87

ALLEGANY

U. S. A.

VIRGINIA

OWN HOME

HOUSEWIFE

MEMORIAL HOSPITAL

CUMBERLAND

211 RACE ST.

ALLEGANY CUMBERLAND X

WYLAND

MARGARET ACCOUNT XXXXXXXX

WILLIAM

WILLIAM

MEMORIAL HOSPITAL, CUMBERLAND, MD.

330 VIRGINIA AVE., CUMBERLAND, MD.

DR. CLAY DURRETT

Cumberland, Md.

Nov. 2, 1968

Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																					
15248 CERTIFICATE OF DEATH 15254																					
1. DECEASED-NAME (Type or print)			First ANDREW			Middle W			Last HELLER			2a. DATE OF DEATH Month 11 Day 17 Year 68			2b. HOUR 7:20 A M						
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 8-9-95			6. AGE (In years last birthday) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 							
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.												
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supt. Street Dept.			12b. KIND OF BUSINESS OR INDUSTRY Municipal												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 115 TILGHMAN ST.									
14. FATHER'S NAME First ANDREW			Middle 			Last HELLER			15. MOTHER'S MAIDEN NAME First ELIZABETH			Middle HEIRE			Last HELLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give war or dates of service) War I			16b. SOCIAL SECURITY NO. 			17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 185X IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatous DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate & colon PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year 10 years 2 years									
19a. DATE OF OPERATION 10/24/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colonic obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 20 Sept , 19 68 , to 17 Nov , 19 68 , that (I) (we) last saw the deceased alive on 10 Nov , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Fred W. Miltenberger												DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR. FRED W. MILTENBERGER			22e. ADDRESS CUMBERLAND, MD.																		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov. 20, 1968			23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.												
24. FUNERAL DIRECTOR James F. Scarpelli			ADDRESS Cumberland, Md.			25a. REC'D BY REGISTRAR DATE NOV 22 1968			25b. REGISTRAR'S SIGNATURE 												

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1. Film 06 11/13/68 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15255

1. DECEASED-NAME (Type or Print) Nora J. Helm			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month NOV. Day 3, Year 1968			2b. HOUR 8:45 PM			
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 2, 1880	6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month NOVEMBER Day 3, Year 1968 8:45 PM			
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 125 Grand Avenue	
14. FATHER'S NAME First John Middle Squires Last			15. MOTHER'S MAIDEN NAME First Sarah Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Carroll Helm, Cumberland, Md. Grandson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5339 (b) Gastric Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Peptic Ulcer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5400									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 3, 1968			
			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

<div>15245</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15256</div>												
1. DECEASED-NAME (Type or print)			First HAZEL		Middle S.		Last HELT		2a. DATE OF DEATH Month 11 Day 06 Year 68		2b. HOUR A 4:05 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 09-02-93			6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY SELF			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 92B SHAMROCK RD., BEL AIR			
14. FATHER'S NAME First GEORGE Middle H. Last SHORNHORST			15. MOTHER'S MAIDEN NAME First (SHARP) Middle LAURA Last SHORNHORST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 192-03-1172		17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u> 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>150X</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Aspiration pneumonia</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/68</u> , to <u>11/6/68</u> , that (I) (we) last saw the deceased alive on <u>11/5/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>[Signature]</u>						22c. DATE SIGNED <u>11/7/68</u>		22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				
22e. ADDRESS 59 GREENE ST., CUMB., MD. 21502												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/8/1968		23c. NAME OF CEMETERY OR CREMATORY Allegheny Co. Memorial Park			23d. LOCATION (City or Town) (County) (State) Pittsburgh,, Allegheny Pa.					
24. FUNERAL DIRECTOR HAVER'S FUNERAL HOME						25. REC'D BY REGISTRAR DATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
CHAPEL OF THE HILLS MORTUARY, LA VALE, MD.												

1925

NO	100-00-1172	SACRED HEART HOSPITAL, 600 SETON DR., CUMM.	GEORGE	H. SHORNFEST (SHAR) LOUIS	SHORNFEST
			ALLEGANY	300 SHAROCK RD., BEL AIR	
			CUMBERLAND		
			PENNSYLVANIA	U.S.A.	ALLEGANY COUNTY,
			WHITE	00-00-00	
			HELT	11	00-00-00

DR. S. G. WEISS ON
 20 GREENE ST., CUMM., MD. 2103

CHapel of the Hills Mortuary, LA VALL, MD.
 NOV 8 1925

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 1-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15248

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5, Film#406 11 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15257

1. DECEASED-NAME (Type or Print) First Middle Last Emma W. Jenkins			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Nov. 7, 1968			2b. HOUR 2 a.m.								
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 13, 1968		6. AGE (In years last birthday) 95 YRS.		7c. DATE PRONOUNCED DEAD Month Day Year Nov. 7, 1968		2d. HOUR 3 a.m.				
7a. BIRTHPLACE (State or foreign country) Corriganville			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Corriganville, Maryland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Private street address			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Corriganville			13d. IN CITY LIMITS? <input type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last David Findley			15. MOTHER'S MAIDEN NAME First Middle Last Susanna Burkett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 217-54-6817			17. INFORMANT ADDRESS Leslie Jenkins, Corriganville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Sclerosis (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Benedict Skitarelis			M.D. Benedict Skitarelis, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED November 7, 1968					
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county) Cumberland, Maryland			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Nov. 10, 1968			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pennsylvania						25a. REC'D BY REGISTRAR NOV 12 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

2001, 1. vol.

Journal of Interpersonal Violence 28(10)

1997

2001, 13, 1993

Summary

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REF ID: A66049

211

1993-1994

NOTES ON CONTRIBUTORS

1

FILE # 100-101010

General Skifford, R. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>15247</div> <div> <div>1</div> <div>15258</div> </div> <div> <div> <div>2</div> <div>1</div> </div> <div> <div>90</div> <div>01</div> </div> </div>											
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Cora</div> <div>Middle</div> <div>A.</div> <div>Last</div> <div>Karns</div> </div>						<div> <div>2a. DATE OF DEATH</div> <div> <div>@ 12 Midnight</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>November 28, 1968</div> <div> <div>2b. HOUR</div> <div>P. M.</div> </div> </div>					
<div>3. SEX</div> <div>Female</div>		<div>4. RACE</div> <div>White</div>		<div>5. DATE OF BIRTH</div> <div>9/1/1881</div>		<div>6. AGE (In years lost birthday)</div> <div>87 YRS.</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>		<div>IF UNDER 24 HRS.</div> <div>HOURS</div> <div>MIN.</div>	
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>Allegany U.S.A.</div>		<div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>Allegany County Md.</div>					
<div>10. CITY OR TOWN OF DEATH</div> <div>Cumberland, Md.</div>		<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Allegany County Infirmary</div>		<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Housewife</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div>					
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div>		<div>13b. COUNTY</div> <div>Allegany</div>		<div>13c. CITY OR TOWN</div> <div>Cumberland</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>220 Utah Avenue</div>			
<div>14. FATHER'S NAME</div> <div>First</div> <div>Charles</div> <div>Middle</div> <div>R.</div> <div>Last</div> <div>Fletcher</div>		<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Honor</div> <div>Middle</div> <div>Martin</div> <div>Last</div>									
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)</div> <div>Yes, no, or unknown</div> <div>No</div>		<div>16b. SOCIAL SECURITY NO.</div> <div>217-54-6807</div>		<div>17. INFORMANT</div> <div>P.O. Box 599, Cumberland, Md.</div> <div>Allegany County Infirmary records.</div>							
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u></div> <div>436.9</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b) <u>Sept. Arteriosclerosis</u></div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>Days</div> <div>Yrs</div>	
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>331X</div>											
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>					
<div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div> <div>P.M.</div> <div>19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>							
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>		<div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>							
<div>22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 21, 1967</u>, to <u>Nov. 28, 1968</u>, that (I) (we) last saw the deceased alive on <u>Nov. 28, 1968</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>											
<div>22b. SIGNATURE</div> <div><u>George M. Simons</u></div> <div>DEGREE</div> <div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div> <div>MED. DIRECTOR</div> <div><input checked="" type="checkbox"/></div> <div>STAFF PHYS.</div> <div><input checked="" type="checkbox"/></div>										<div>22c. DATE SIGNED</div> <div><u>11/30/68</u></div>	
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>Dr. George M. Simons, MD</div>				<div>22e. ADDRESS</div> <div>Memorial Hospital, Cumberland, Md.</div>							
<div>23a. BURIAL, CREMATION, REINTERMENT</div> <div>Burial</div>		<div>23b. DATE</div> <div>Dec. 1, 1968</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Greenmount Cemetery</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Cumberland, Allegany, Md.</div>					
<div>24. FUNERAL DIRECTOR</div> <div>James F. Scarpelli, Cumberland, Md.</div>				<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>DEC 6 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div><u>Charles Judge</u></div>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15248

15259

1. DECEASED-NAME (Type or print) WILLIAM H. KASTNER			2a. DATE OF DEATH Month NOVEMBER Day 22 Year 1968 9:30 P.M. HOUR		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-19-1890	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ALLEGANY		6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 617 PATTERSON AVE.			
14. FATHER'S NAME First Middle Last ANTHONY KASTNER			15. MOTHER'S MAIDEN NAME First Middle Last MARY W. GROSS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis Heart Disease Obstruction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
22a. I certify that (I) (this hospital) attended the deceased from 8 , 19 68 , to 11/22 , 19 68 , that (I) (we) last saw the deceased alive on 11/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. S.G. Weisman MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11/25/68	
22d. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN				22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/20/68		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul	
23d. LOCATION (City or Town) (County) (State) Cumberland Md.		23e. REC'D BY REGISTRAR Charles Judge			
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.		25a. DATE NOV 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000

WILLIAM

KASTNER

NOVEMBER 25, 1969 9:30

MALE

WHITE

11-17-1940

MARYLAND U.S.A.

ALLIGDAY

CUMBERLAND

NEONATAL HOSPITAL

RETIRED

MARYLAND

CUMBERLAND

617 PATTERSON AVE.

ANTHONY

KASTNER

MARY

GROSS

NEONATAL HOSPITAL, CUMBERLAND, MD.

DR. S. WEISSMAN

24 REESE ST., CUMBERLAND, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15249

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15260

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Edwin James Keyser						Nov. 3, 1968			11:00a					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	May 4, 1901	67 YRS	MONTHS	DAYS	HOURS	MIN.	November 3, 1968			11:00a			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U S A						Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			Sts Peter & Paul's Rectory Kitchen			Machinist			Kelly Springfield					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			429 Broadway		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
C. Frank Keyser			Anna L. Pyle			Yes			217-14-4819			Mrs. Pauline N. Keyser 429 Broadway		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												SUDDEN		
IMMEDIATE CAUSE (a) 4109														
DUE TO, OR AS A CONSEQUENCE OF														
(b) CORONARY OCCLUSION														
DUE TO, OR AS A CONSEQUENCE OF														
(c) CORONARY SCLEROSIS												--		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
4201														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH				HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				22b. DATE SIGNED						
EXAMINER'S NAME (Type)								Nov 3, 1968						
								CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)		
Burial				Nov. 6, 1968				Hillcrest Burial Park				Near Cumberland Alleg Md.		
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
John J. Hafer, Jr.				230 Balto Ave., Cumberland Md				NOV 6 1968				Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15250		CERTIFICATE OF DEATH						15261			
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH			2b. HOUR		
Wesley Klipstein						11/9/1968			M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		1/13/1881			87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
MD.		USA.				Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Minnea Hospital			Retired Coal Miner					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD.			Allegany		Lonaconing		Rural				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Klipstiene			Susan Meyers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			215-36-8754		Sarah Green			Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage (Daughter) 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331X (b) Generalized Arteriosclerosis years (c)										36 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Insufficiency											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1960, to Nov. 9, 1968, that (I) (we) last saw the deceased alive on Nov. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
L.R. MILES JR., M.D.			11.9.68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
L.R. MILES JR., M.D.			LONA CONING MD, 21539								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/11/1968			Laurel Hill Cemetery			Moscow, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
George Eichhorn			Lonaconing, Md.			DATE NOV 12 1968			f Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

15251										15262													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)				First FLORENCE				Middle Viola				Last LAUDER				20. DATE OF DEATH Month 11 Day 28 Year 68				2b. HOUR 3:10PM			
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH 1-18-99				6. AGE (In years lost birthday) 69 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? UNITED STATES				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY COUNTY Md.											
10. CITY OR TOWN OF DEATH CUMBERLAND,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk & HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY Dept. Store											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 889 MC MULLEN HIGHWAY							
14. FATHER'S NAME First ROBERT				Middle M				Last RUSSELL				15. MOTHER'S MAIDEN NAME First JEANETTE				Middle --				Last HERRON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. 214-16-2059				17. INFORMANT Address Mrs. John J. Devlin, 889 McMullen Hwy. Cumb. Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion																1 day							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4201																							
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure																5 wks.							
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease																25 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Esophagitis, gastritis, Generalized arteriosclerosis																							
19a. DATE OF OPERATION none				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? none											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Nov. 4, 1968 , to Nov. 28, 1968 , that (I) (we) last saw the deceased alive on Nov. 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 3.10 P. M.																							
22b. SIGNATURE James P. Hallinan, M.D.																22c. DATE SIGNED 11-28-68							
22d. PHYSICIAN'S NAME (Type) JAMES P. HALLINAN, M.D.																22e. ADDRESS 140 BEDFORD STREET, CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12/1/68				23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.											
24. FUNERAL DIRECTOR H. Wayne George ADDRESS GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD.																25a. REC'D BY REGISTRAR DEC 3 1968				25b. REGISTRAR'S SIGNATURE Charles George			

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UNITED STATES ILLINOIS COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

15258		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15263					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First JOHN		Middle WILLIAM		Last LOAR		2a. DATE OF DEATH Month NOVEMBER Day 28 Year 1968		2b. HOUR A. 3:25 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPTEMBER 5, 1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY SELF					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN RAWLINGS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First CHARLES		Middle W.		Last LOAR		15. MOTHER'S MAIDEN NAME First ELEANOR		Middle M.		Last GRACIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-34-1519		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro intestinal hemorrhage 5340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastro intestinal ulceration DUE TO, OR AS A CONSEQUENCE OF (c) (multiple) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days 15 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5420											
19a. DATE OF OPERATION Nov. 27, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding stomach				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov 10 , 19 68 , to Nov 28 , 19 68 , that (I) (we) last saw the deceased alive on Nov 27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. DONALD B. GROVE						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 29, 1968	
22d. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE						22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg Alleg Md					
24. FUNERAL DIRECTOR John N. Hafer, Jr.				ADDRESS 230 Balto Ave. Cumberland Md		25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
CHARLES			Edward			LYTLE			11 21 68 9:12 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE		WHITE		08-03-89			79 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last 12 months)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			SELF-EMPLOYED		AUTO PARTS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND			887 PATTERSON AVENUE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
DANIEL			LYTLE			(RUEHL) SOPHIA LYTLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES			220-07-6908		SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal artery stenosis</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>Nov. 4</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Nov. 2</u> , 19 <u>65</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. M. Schindler</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/65</u>			
22d. PHYSICIAN'S NAME (Type) B. M. SCHINDLER, M.D.				22e. ADDRESS 43 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11/23/68		Rose Hill Cemetery		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GEORGE FUNERAL HOME 202 GREENE ST., CUMB., MD.						DATE NOV 25 1968		<u>Charles Judge</u>	

MEDICAL CERTIFICATION

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U.S.A. ALLEGANY COUNTY

SELF-EMPLOYED AUTO PARTS

887 PATTERSON AVENUE

LYTLE (LOEHL) SOPHIE

220-07-8008 SACRED HEART HOSPITAL, 200 SETON DR., CUM...

40 GREENE ST., CUMID., NO. 21502

2.4. SCHINDLER, F.D.

GEORGE FUNERAL HOME 200 GREENE ST., CUMID., NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15254										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15265																																							
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR P																																							
First Middle Last										Month Day Year										10:30 AM																																							
PAUL										P.										MANSFIELD																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
MALE										WHITE										11-13-01										66 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
MARYLAND										U.S.A.																				ALLEGANY COUNTY																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										SACRED HEART HOSPITAL										Retired Machinist										RAILROAD																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										CUMBERLAND										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										677 FAYETTE STREET																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										Address										MD. 21502																													
First Middle Last										First Middle Last																																																	
WILLIAM T. MANSFIELD										(BRENNAN) MARY E. MANSFIELD																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> unknown <input type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										705-05-4773										SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) <i>1533 metastatic Carcinoma of liver</i>										DUE TO, OR AS A CONSEQUENCE OF										3 years																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <i>Carcinoma of sigmoid</i>										DUE TO, OR AS A CONSEQUENCE OF										3 years																													
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <i>12 Oct</i> , 19 <i>68</i> , to <i>10 Nov</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10 Nov</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <i>James B. Stegmair, M.D.</i>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>11 Nov. 68</i>																																							
22d. PHYSICIAN'S NAME (Type) J. G. STEGMAIER, M.D.										22e. ADDRESS <i>122 S. CENTRE ST., CUMB., MD. 21502</i>																																																	
23a. BURIAL, CREMATION REMOVAL (Specify)										23b. DATE <i>11/13/68</i>										23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter & Paul</i>										23d. LOCATION (City or Town) (County) (State) <i>Cumberland Allegany Md</i>																													
24. FUNERAL DIRECTOR <i>Louis Stein Inc.</i>										25a. REC'D BY REGISTRAR <i>NOV 14 1968</i>										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																																							
STEIN FUNERAL HOME, 117 FREDERICK ST., CUMB., MD.																																																											

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U. S. STEPHENSON

122 S. CENTRE ST., CLARK, CO. 71502

STEIN FURNACE, 117 FIDELITY ST., CORP., INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>15255</div> <div> <div>3</div> <div>1</div> <div>4</div> </div> <div> <div>15266</div> <div>2</div> <div>1</div> </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
<div>First</div> <div>Middle</div> <div>Last</div> <div>ETHEL L. MC BRIDE</div>						<div>Month</div> <div>Day</div> <div>Year</div> <div>11 20 68</div>			<div>1:25M</div>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		07-29-13		55 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY COUNTY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT. #4, BOX 38, OLDTOWN RD.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
<div>First</div> <div>Middle</div> <div>Last</div> <div>GEORGE NIXON</div>				<div>First</div> <div>Middle</div> <div>Last</div> <div>ELLA ARNOLD NIXON</div>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address	
NO						SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,				MD. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum of metastatic</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
<u>154x</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
11-1-68		Carcinoma of rectum			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>68</u> , to <u>11-20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Andrew Stasko</u>										11-20-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
ANDREW STASKO, M.D.						401 DECATUR ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Nov. 22, 1968		Davis Memorial Cemetery		Cumberland		Allegany		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>James F. Scarcelli</u>						NOV 22 1968		<u>Charles Judge</u>			
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.											

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ALL COUNTY

RT. 20. 35.

CLONIA ALLE

100-443887-1000

SCARFELLI FUNERAL HOME, 100 W. WAVE, CULVER, IND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME Type of death MARGARET		First FREDA		Middle E		Last MC ELFISH		2a. DATE OF DEATH Month 11 Day 5 Year 68		2b. HOUR 9:45A M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10-23-19		6. AGE (In years lost birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OEN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 3, BOX 123		
14. FATHER'S NAME First GIDEON Middle MULL Last RHODES		15. MOTHER'S MAIDEN NAME First LUCY Middle RHODES Last RHODES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217 10 7690		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma Brain 174X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma breast DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 7 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19____, to 11-5 , 19 68 , that (I) (we) lost saw the deceased alive on 11-5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William P. James DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 11/6/68		
22d. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.				
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

15320

APR 28 11 58 AM '48

WHITE 10-2-13
FEMALE
U.S.A.
ALLIANCE

GENERAL HOSPITAL
ALLEGANY CUMBERLAND
X R.T. 3, BOX 123

WILL LUCY RHODES
GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

GENERAL HOSPITAL
CUMBERLAND, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Bp 2

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15268

1. DECEASED-NAME (Type or Print)			First JANE			Middle LOUISA			Last McGOYE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Nov. 23, 1968				2b. HOUR 7am	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 29, 1880		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD Month November Day 23 Year 1968				2d. HOUR 11:00 M	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH FROSTBURG				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 49 E. MAIN STREET				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 49 E. MAIN STREET							
14. FATHER'S NAME First FRANK			Middle WINTERS			Last MARY			15. MOTHER'S MAIDEN NAME First MARY			Middle BUSKIRK			Last BUSKIRK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-58-0222				17. INFORMANT MRS. PAUL CUTTER, RT. 2, FROSTBURG, MD.				ADDRESS Box 28,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS (b) --- DUE TO, OR AS A CONSEQUENCE OF --- (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC MYOCARDITIS, ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED November 5, 1968									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 11-7-68				23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH CEMETERY									
				23d. LOCATION (City or Town) (County) (State) MIDLAND, MD.													
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				ADDRESS 21532				25a. REC'D BY REGISTRAR NOV 12 1968									
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
30M REV. 1-68

15258 Item#5, Film#407 12/3/68 km										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15269																																							
1. DECEASED-NAME (Type or print)										First MARY Middle K. Last METZ										2a. DATE OF DEATH										2b. HOUR																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
FEMALE										WHITE										2-18-1888										81																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MARYLAND										U. S. A.																				ALLEGANY																													
10. CITY OR TOWN OF DEATH.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during major part of year or if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										MEMORIAL HOSPITAL										HOUSEWIFE																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										BARTON										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
GEORGE ROBERTSON										KATHERINE SIMONS																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										214-16-2521										MEMORIAL HOSPITAL, CUMBERLAND, MD.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										Cerebrovascular Accident										30KS																													
431.9										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
331X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 19 68, to Nov 15, 19 68, that (I) (we) lost saw the deceased alive on Nov 15, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
HE Spiggle										Nov 21 '68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
BRADDOCK MEDICAL GROUP										CUMBERLAND, MD.																																																	
23a. BURIAL, CREMATION, or other disposition										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										11/18/68										Laurel Hill										Moscow Mills Alle. Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
E. J. Boral										Westernport, Md.										DATE NOV 25 1968										James Judge																													

NOVEMBER 15, 1931
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15258		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15270	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) First Middle Last Alta Marie Mickey			2a. DATE OF DEATH Nov. Month 3, Day 68 Year			2b. HOUR A. M. 8:45 M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 15, 1914		6. AGE (In years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Reg. Nurse,		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rt. # 1 Furnace Acres		14. FATHER'S NAME First Middle Last Fred -- Larson		15. MOTHER'S MAIDEN NAME First Middle Last Lenora -- Sheehan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-30-2085		17. INFORMANT Mr. Donald R. Mickey, Rt. # 1 Ridgeley, W. Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since 2/27/53</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27/53</u> , to <u>11-3-68</u> , that (I) (we) lost the deceased alive on <u>9-19-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Wm. J. Williams</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-5-68	
22d. PHYSICIAN'S NAME (Type) W. Fred Williams, M. D.		22e. ADDRESS 122 So. Centre St. Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/6/68		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Ashby, Mineral W. Va.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR OATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

12370

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STATE OF TEXAS

County of _____ State of Texas

Know all men by these presents, that _____

of the County of _____ State of Texas

do hereby certify that _____

is the true and correct copy of the _____

as the same appears from the _____

and is a true and correct copy of the _____

as the same appears from the _____

and is a true and correct copy of the _____

as the same appears from the _____

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and is a true and correct copy of the _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15260									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First VERNA		Middle DeVore		Last MILLER		2a. DATE OF DEATH NOVEMBER 17, 1968	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-25-1916		6. AGE (In years last birthday) 52		7b. HOUR 5:12 PM	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 116 JANE CRAIGER	
14. FATHER'S NAME First CHARLES Middle E. Last DEVORE		15. MOTHER'S MAIDEN NAME First MARY Middle Ellen Last KNEFE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)		16b. SOCIAL SECURITY NO. 232-26-2828		17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 5719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 5810									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-15, 1968, to 11-17, 1968, that (I) (we) last saw the deceased alive on 11-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew Stasko MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/17/68			
22d. PHYSICIAN'S NAME (Type) DR. ANDREW STASKO		22e. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/21/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.			
24. FUNERAL DIRECTOR Philip B. Wendt		ADDRESS 121 Memorial Avenue, City		25a. RECEIVED BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) Gerald D. Mosler						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year Nov. 7, 1968			2b. HOUR 1 a m		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 10, 1910		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) Germany			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 36 North George Street				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manufacturers Rep.			12b. KIND OF BUSINESS OR INDUSTRY Clothing
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Virginia						13b. COUNTY Alexandria		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2240 Arlington Terr.						13f. CITY OR TOWN Alexandria					
14. FATHER'S NAME Hugo Mosler						15. MOTHER'S MAIDEN NAME Elsa Wunderlich					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16b. SOCIAL SECURITY NO. 219-14-2183		17. INFORMANT ADDRESS Mr. Robert Lainof, Alexandria, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Left DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109 (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22b. DATE SIGNED November 7, 1968						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park				23d. LOCATION (City or Town) (County) (State) Falls Church, Va.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

15002

15002

Male	White	10/10/1910	56	November 7, 1958	1
Germany	USA				
Underland	56 North George Street	Manufacturers Ltd.			
Virginia	Alexandria	2540 Arlington Terr.			
Info	Monitor	Niam Underlich			
no	212-34-2183	Mr. Robert Leland, Alexandria, Virginia			
	Coronary	Thrombosis, left	Baden		
	Coronary	Coronaria	---		

XX
X
X
X
X

James F. Scarborough, Cumberland, Md.
 Burial Nov. 1, 1958 National Memorial Park
 Fallis Church, Va.
 CUMBERLAND, MARYLAND
 November 7, 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) DALE			First Middle Last Ward Mullenex			2a. DATE OF DEATH Month Day Year NOVEMBER 13, 1968			2b. HOUR 12:50P
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 08-29-10			6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done) WESTERN MARYLAND RR Engineer		12b. KIND OF BUSINESS OR Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) WEST VIRGINIA			13b. RURAL <input checked="" type="checkbox"/> URBAN <input type="checkbox"/>		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1 Miller Rd.
14. FATHER'S NAME First Middle Last CHARLES -- Mullenex			15. MOTHER'S MAIDEN NAME First Middle Last Sallie -- MULLENAUX						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 705-10-7686		17. INFORMANT Address SACRED HEART HOSP. RECORD-900 SETON DR.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5321 <i>Deeply Bleeding Aortic Rupture</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 541.1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1965</i> , to <i>Nov 13, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Blane Schindler</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11/14/68</i>			
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/16/68		23c. NAME OF CEMETERY OR CREMATORY McNeeley Cemetery		23d. LOCATION (City or Town) (County) (State) Hendricks, Tucker, W. Va.			
24. FUNERAL DIRECTOR GEORGES H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

12208

12273

DATE

AGE

HOBBIES

NOVEMBER 13, 1952

12:30

HAIR

WHITE

0-29-10

2

ST VIRGINIA

USA

ALLGARY

CHESLAND, MD.

SACRED HEART HOSPITAL

WESTERN MARYLAND RR

ST VIRGINIA

LIBERAL

INDICELY

X ROUTE 1, MARYLAND

CHARLES

--

WILLIAM

SACRED

--

WILLIAM

NO

205-10-7506

SACRED HEART HOSP. RECORD-300 SECTION

DR. BLAKE SCHINDLER

AS GREENE ST., CHESLAND, MD.

GEORGE

NOV 13 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
15268					15274							
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR		
First Middle Last Charles Walter Neil					Nov. Month 8 Day 1968 Year					9:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Feb. 17, 1883			85 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Penna.		USA				Allegany Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland			Sylvan Retreat			Retired Conductor			Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		705 Virginia Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last Richard B. Neil			First Middle Last Beulah Ann Thomas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No					Mrs. Bertha Neil, Cumberland, Md., Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 440.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from March 13, 1967, to Nov. 8, 1968, that (I) (we) last saw the deceased alive on Nov. 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE George M. Simons						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/9/68				
22d. PHYSICIAN'S NAME (Type) Dr. George M. Simons, M.D.						22e. ADDRESS Memorial Hospital, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial			Nov. 11, 1968		Hillcrest Burial Park		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James P. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge				

15252

15252

Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D.

Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md.

Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D.

Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md.

Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D. Mr. George H. Simpson, M.D.

Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

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Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

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Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

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Nov. 1, 1938 Nov. 1, 1938 Nov. 1, 1938

Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md. Memorial Hospital, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15264

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15275

1. DECEASED-NAME (Type or print)		First GOLDEN		Middle B.		Last NIXON		2a. DATE OF DEATH Month 11 Day 29 Year 68		2b. HOUR 9:30 A.M. <input checked="" type="checkbox"/> P.M. <input type="checkbox"/>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-20-1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. #2, WILLIAMS RD.,			
14. FATHER'S NAME First COLUMBUS Middle NIXON Last NIXON		15. MOTHER'S MAIDEN NAME First ELIZA Middle LEASURE Last LEASURE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 185X IMMEDIATE CAUSE (a) Ca Prostate & wife metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-27											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. County of Allegany City or Town Golden County Allegany State MD							
22a. I certify that (I) (this hospital) attended the deceased from 2/4/67 , 19 67 , to 11/29/68 , 19 68 , that (I) (we) last saw the deceased alive on 11/29/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. R. J. WILLIAMS		22c. DATE SIGNED 12/3/68		22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY		23d. LOCATION (City or Town) (County) (State) OLDTOWN, MD.					
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

14

8-50-1203

YMA23-11A

MEMORIAL HOSPITAL

U. S. WILLIAMS, JR.

221-12

REF ID: A6110261-CONFIDENTIAL

135 2. CENTRE 21, GIMBERLAND, 12 1970

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15265

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15276

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year				2b. HOUR
ERNEST			W.		NORRIS	OF ESTI- DEATH MATED <input type="checkbox"/> Nov. 20, 1968				5:40 p
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	DEC. 3, 1885	82 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	5:40 p	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
MT. SAVAGE			MEMORIAL HOSPITAL			SHOP MAN			C&P R.R.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		WASHINGTON STREET ALGONQUIN HOTEL	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WILLIAM NORRIS			ELIZABETH WILLS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
						MRS. VIRGIL NICKEL, CUMBERLAND, MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										4-5 days
IMMEDIATE CAUSE (a) Lobar Pneumonia, bilateral										
DUE TO, OR AS A CONSEQUENCE OF										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
9046 Nasal and Malar bone fracture										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
CAUSE OF DEATH			9:25 P.M. 10-25-68			Sustained a Fall				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
			Sidewalk			Algonquin Hotel, Cumberland, Alleg. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
22b. DATE SIGNED										
ACTUAL SIGNATURE			Benedict Skitarelic M.D.							
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			NOV. 23, 1968		ST. GEORGE EPISCOPAL			MT. SAVAGE, MD.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD. 21532						NOV 25 1968		Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Thomas A. O'Neill						Month Day Year			12:30
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	Apr. 8, 1882	86 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	1:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10d. Md.
Cumberland, Md.		U.S.A.				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland Md.		Sacred Hospital — DOA			Retired Pipefitter.			Self	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland			Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	619 N. Center Street.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward O'Neill			Mary Ann Kean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO.					Hugh O'Neill Cumberland Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								SUDDEN	
IMMEDIATE CAUSE (a)								CORONARY OCCLUSION	
DUE TO, OR AS A CONSEQUENCE OF								CORONARY SCLEROSIS	
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			NOVEMBER 18, 1968
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		Nov. 21, 1968	St. Patrick's Cem.			Cumberland Md.		(Allegany)	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Louis Stein Inc. Cumb. Md.					DATE NOV 21 1968		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

15267												15278											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)				First HARRY				Middle A				Last PARKER				2a. DATE OF DEATH Month 11 Day 30 Year 68				2b. HOUR 2:32 P M			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH 6-6-89				6. AGE (In years lost birthday) 79 YRS.				IF UNDER 1 YEAR MONTHS OAYS				IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign) WEST VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY				Md.							
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 854 MD. AVENUE							
14. FATHER'S NAME First JOHN				Middle PARKER				15. MOTHER'S MAIDEN NAME First VERLINDA				Middle LINGO				Last LINGO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RO hypostatic pneumonia 185X DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia cancer metastases DUE TO, OR AS A CONSEQUENCE OF (c) Ca of prostate metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 12 wks 12 month											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177X arteriosclerotic heart disease																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 1-0 , 19 68 , to 11-30 , 19 68 , that (I) (we) last saw the deceased alive on 11-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Walter P. Drass												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12-2-68							
22d. PHYSICIAN'S NAME (Type) DR. W. A. HIMMLER												22e. ADDRESS CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12/3/1968				23c. NAME OF CEMETERY OR CREMATORY Indian Mound				23d. LOCATION (City or Town) (County) (State) Romney Hampshire W.Va.											
24. FUNERAL DIRECTOR Keith Paffer				ADDRESS Romney W.Va.				25a. REC'D BY REGISTRAR DATE DEC 9 1968				25b. REGISTRAR'S SIGNATURE Charles Judge											

10000

10000

HARRY A PARKER 11 30 00 1:32

MALE WHITE 64-80 ALLEGANY WEST VIRGINIA U.S.A. X

CUMBERLAND MEMORIAL HOSPITAL ALLEGANY CUMBERLAND X 825 NO. AVENUE

JOHN PARKER NEWLINA CUMBERLAND, MD. MEMORIAL HOSPITAL CUMBERLAND, MD. LINDO

DR. W. A. HINLER CUMBERLAND, MD.

DEC 1 1983

15268

CERTIFICATE OF DEATH

15279

1. DECEASED-NAME (Type or print) BABY BOY RAUPACH			2a. DATE OF DEATH NOVEMBER 12, 1968		2b. HOUR 7:32 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH NOVEMBER 12, 1968		6. AGE (In years lost birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS 41
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) SACRED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.) NONE	12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER SACRED HEART HOSP.
14. FATHER'S NAME First Middle Last EARL WILLIAM RAUPACH		15. MOTHER'S MAIDEN NAME First Middle Last KAREN LOUISE SOETHE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT HOSPITAL RECORD, CUMBERLAND, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 7599 DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Congenital Anomalies. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7593					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert D. Brodell M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL				22e. ADDRESS 500 GREENE ST., CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE 11/21/68		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany MD					
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. MD.		25a. REC'D BY REGISTRAR DATE NOV 21 1968		25b. REGISTRAR'S SIGNATURE William C. Under	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12579

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FACT WHITE NOVEMBER 1, 1981
BABY BOY NOVEMBER 1, 1981
12579

KORLAND USA X ALLEGANY
CINDERLAND, X SACRED HALL 1981
12579

NO HOSPITAL RECORD, CINDERLAND, MO
LOUISE KAPEN
12579

DR. ROBERT O. BROOKS
500 GLENE ST., CINDERLAND, MO. 21502

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed, within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. This pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15269

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15280

1. DECEASED-NAME (Type or Print) FRANCIS JOSEPH READ			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year 11/8/68 19 68			2b. HOUR 3P M			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH NOV. 30, 1893	6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year NOV. 8 1968	2d. HOUR 3P M
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA SACRED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY RAYON FACTORY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY CUMBERLAND		13c. CITY OR TOWN POTOMAC PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last JOHN READ			15. MOTHER'S MAIDEN NAME First Middle Last LOUISA KUHN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW 1 217 10 1602		17. INFORMANT F. J. READ			ADDRESS CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301									
19a. DATE OF OPERATION 4301		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED NOV. 8, 1968			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, town, county, state) ROUTE 9, CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

12330

12330

FOX STATE
HEALTH UNIT



NOV 1 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> 15270 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15281 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) First FLODA Middle MAE Last ROBINETTE						2a. OATE OF DEATH NOVEMBER 21 Day 1968			P. M. 8:45 M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-29-1893			6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of last year) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 2, CREEK ROAD	
14. FATHER'S NAME First GEORGE Middle GOLDZEN Last WATSON			15. MOTHER'S MAIDEN NAME First SARAH Middle WATSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-50-2398			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4380 IMMEDIATE CAUSE (a) Acute Cardiac Decomposition DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov 21 , 19 68 , to Nov 21 , 19 68 , that (I) (we) last saw the deceased alive on Nov 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Clay Durrett DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. OATE SIGNED 11/22/68					
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT						22e. ADDRESS 236 VA. AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/24/1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md					
24. FUNERAL DIRECTOR Charles E. Hafer ADDRESS Charles E. Hafer, 230 Balto Ave, Cumberland, Md						25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15272

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15282

1. DECEASED-NAME (Type or print) William Baron Sampsell			2a. DATE OF DEATH Month Nov. Day 17 Year 1968			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 16, 1901		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 123 Humbird St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Machinist		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 123 Humbird St.							
14. FATHER'S NAME First Middle Last Henry George Sampsell				15. MOTHER'S MAIDEN NAME First Middle Last Cora Pouder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Layfaunn Sampsell, Cumberland-Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1968 , to Nov. 17, 1968 , that (I) (we) lost the deceased on Nov. 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Clay E. Durrett DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Nov. 18, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.				22e. ADDRESS 236 Virginia Ave., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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U.S. Bureau of Census

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John Fowler

Henry George & Company

Mr. Raymond Campbell, Cumberland-ville

250 Virginia Ave., Cumberland, Md.

10. 1977. - 1978. 10.

• *Staph. aureus* (100%)

NOV 20 1961

[illegible]

FOR STATE HEALTH DEPT

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15272

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15283

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
William Norman Schaidt						Nov. 1, 1968			7:00 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	Nov. 15, 1915	52	MONTHS DAYS		HOURS MIN.		November 1, 1968			11:00 P.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Allegany			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Oldtown			Memorial Hospital-DOA			Former Carman Helper			Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Allegany			Oldtown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			None		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
John D. Schaidt			Clara B. Furstenberg											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
yes			War II			Mr. Joseph M. Schaidt, Oldtown, Md. Brother								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4190</u> Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Coronary Sclerosis (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden -----		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Hypertensive Cardiovascular Disease (Myocardial Hypertrophy)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 1, 1968					
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Nov. 4, 1968			Oldtown Cemetery			Oldtown, Md. Allegany					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.						NOV 6 1968			Charles Judge					

Nov. 1, 1968 7:00 PM

November 1, 1968 11:00 PM

Allegany

Oldtown

Allegany Oldtown

John D. Schmidt

Mr. Thomas H. Schmidt, Oldtown, Md. Brother

Coronary Occlusion

Coronary Sclerosis

Hypertensive Cardiovascular Disease (Myocardial Hypertrophy)

November 1, 1968

Oldtown, Md. Allegany

Oldtown Cemetery

Oldtown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 407 12-9-68a													
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
15273													
15284													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First ALICE		Middle V.		Last SCHRAMM		2a. DATE OF DEATH Month NOVEMBER Day 28 Year 1968		2b. HOUR A 3:15 M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH SEPTEMBER 6, 1895			6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 249 N. MECHANIC ST.	
14. FATHER'S NAME First JAMES Middle ALBERT Last BROWN			15. MOTHER'S MAIDEN NAME First VIRGINIA Middle LEE Last YEW										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X <i>General Convulsions</i> DUE TO, OR AS A CONSEQUENCE OF (b) Primary - Breast DUE TO, OR AS A CONSEQUENCE OF (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 27, 1968 to Nov 28, 1968 , that (I) (we) last saw the deceased alive on Nov 27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B. M. Schindler						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11/30/68				
22d. PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER						22e. ADDRESS 59 GREENE STREET, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE DECEMBER 1, 1968		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) RFD #3 CUMBERLAND ALLEGANY MD.					
24. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE			ADDRESS DECATUR ST			25a. REC'D BY REGISTRAR DATE DEC 3 1968			25b. REGISTRAR'S SIGNATURE <i>W. C. Jones</i>				

100

REARLE WHITE

CHAMBERLAIN, W.D. MEMORIAL HOSPITAL

MEMORIAL HOUSE, CHICAGO, ILL.

19 GREEN STREET, CAMBRIDGE, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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15277

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15285

1. DECEASED NAME (Type or Print) Asa Fry Shuck			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Nov Day 1 Year 1968			2b. HOUR 1:30 AM <input type="checkbox"/> PM <input type="checkbox"/>		
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH March 6, 1898	6. AGE (In years lost birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 75 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month Nov Day 1 Year 1968		
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Eckhart			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Hollow Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY Ag.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penn.			13b. COUNTY Somerset		13c. CITY OR TOWN Myersdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rfd. #2	
14. FATHER'S NAME First William Middle Hugh Last Shuck			15. MOTHER'S MAIDEN NAME First Rachel Middle Jane Last May					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 175-16-9574		17. INFORMANT Dalton H. Shuck ADDRESS Meversdale, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			November 1, 1968		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/4/68	23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY			23d. LOCATION (City or Town) (County) (State) MEYERSDALE, PENNA.		
24. FUNERAL DIRECTOR Edward M. Lawrence			ADDRESS 40 West Main St. Frostburg, Md.			25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 407 12/3/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15286

1. DECEASED-NAME (Type or Print) EDNA			First M.			Middle SKIDMORE			Last			2a. DATE KNOWN OF DEATH ESTIMATED Month 11 Day 12 Year 1968			2b. HOUR A.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-15-98/1897		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 70		IF UNDER 24 HRS HOURS 70		2c. DATE PRONOUNCED DEAD Month 11 Day 12 Year 1968		2d. HOUR A.M.					
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY				Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY HOME							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN ECKHART MINES				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET AND NUMBER ECKHART MINES, MD. 21532			
14. FATHER'S NAME SAMUEL				First DUCKWORTH				Last LIBBY				15. MOTHER'S MAIDEN NAME LIBBY				First MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 214-01-6247				17. INFORMANT PT'S HOSP CHART				ADDRESS SACRED HEART HOSPITAL 900 SETON DRIVE CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROTHORAX, BILATERAL: MARKED DUE TO, OR AS A CONSEQUENCE OF 887X MULTIPLE INFARCTIONS OF LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURE OF RIGHT HUMERUS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 44 Days																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9040 HYPERTENSIVE CARDIOVASCULAR DISEASE, CARDIAC HYPERTROPHY, DIABETES																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 8:00 P.M. Sept. 24 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FELL AT HOME											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME				21f. LOCATION Street or R.F.D. No. ECKHART, ALLEGANY, MARYLAND				City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE: Benedict Skitarelic				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED NOVEMBER 12, 1968							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) BALTIMORE PIKE CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 11-15-1968				23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL				23d. LOCATION (City or town) (County) (State) LA VALE MD							
24. FUNERAL DIRECTOR DURST FUNERAL HOME				ADDRESS 57 FROST AVE FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR NOV 18 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) EARL			First Middle Last E. SMITH			2a. DATE OF DEATH Month 11 Day 24 Year 1968			2b. HOUR 10:20 A.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-27-1904		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HSOPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Germanese		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ROUTE #1,	
14. FATHER'S NAME First Middle Last WILLIAM SMITH			15. MOTHER'S MAIDEN NAME First Middle Last IDA KENNEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 168-03-1445		17. INFORMANT Address MEMORIAL HOSPITAL- CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retapentared fibrosarcoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 158X									
19a. DATE OF OPERATION April 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED See above		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/13 , 19 68 , to 11/24 , 19 68 , that (I) (we) last saw the deceased alive on 11/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas F. Lewis M.D.						DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR. THOMAS F. LEWIS						22e. ADDRESS 500 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORY Cooks Cemetery		23d. LOCATION (City or Town) (County) (State) Wellersburg Somerset Pa			
24. FUNERAL DIRECTOR Harvey T. Ziegler				ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

15713

15287

TESTIMONY OF DEATH

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SMITH

E.

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11-27-1904

WHITE

MALE

ALLEGANY

U. S. A.

PENNA.

MEMORIAL HOSPITAL

CUMBERLAND

ROUTE 41

GEORGE HYNDMAN

PENNA.

NEWELL

12A

SMITH

WILLIAM

1 - 11 - MEMORIAL HOSPITAL - CUMBERLAND, MD.

[Faint handwritten text]

500 GREENE ST., CUMBERLAND, MD.

DR. THOMAS F. LEWIS

DEC 9 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carabap papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

15277										15288									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First SMITH		Middle EMILY		Last E		2a. DATE OF DEATH Month 11 Day 8 Year 68				2b. HOUR 1:12 PM							
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-9-09				6. AGE (In years lost birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS 59 DAYS 1 HOURS 12 MIN.		IF UNDER 24 HRS. HOURS 1 MIN.							
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tube Dept.				12b. KIND OF BUSINESS OR INDUSTRY Tire									
13a. USUAL RESIDENCE (Where deceased admission) MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 625 MARYLAND AVENUE											
14. FATHER'S NAME First FRANK Middle EDENHART Last EDENHART		15. MOTHER'S MAIDEN NAME First ELLA Middle MC GOWAN Last MC GOWAN																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. John W. Smith, Husband				Address Cumberland, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 581.0																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ascites and liver enlargement.				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 68 , to 11-8 , 19 68 , that (I) (we) last saw the deceased alive on 11-8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Carlton Brinsfield		DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-10-68									
22d. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD		22e. ADDRESS CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, REMOVING (Specify)		23b. DATE Nov. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.													
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge													

James W. Scott, Jr., Comptroller

Ans: [illegible] [illegible] 8.021, 11. Nov. 1961

DR. CARLTON BASTIEN
CO-ORDINATOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 15278 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15289 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) Martha Elizabeth Snyder						2a. DATE OF DEATH 11/13/1968 at 7:15 A.M.			2b. HOUR A. M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1/4/1892			6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Worker at Celanese			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 415 Race Street		
14. FATHER'S NAME First Middle Last Jerome Ricker Swartley				15. MOTHER'S MAIDEN NAME First Middle Last Anna Virginia Rohrer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown				16b. SOCIAL SECURITY NO. 214-05-6936A		17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 acute renal insufficiency. DUE TO, OR AS A CONSEQUENCE OF (b) A.S. DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Ca. Skeletal System. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4500										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx 12 days many years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Primary carcinoma of breast. Unresected carcinoma. dx ASH D											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 29, 1968 , to Nov. 13, 1968 , that (I) (we) last saw the deceased alive on Nov. 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John A. Lepper M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 11-13-68					
22d. PHYSICIAN'S NAME (Type) John A. Lepper M.D.						22e. ADDRESS Memorial Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. ADDRESS						25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

References

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68

SP2111

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

a.

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10. 11. 1911

[Faint bleed-through from the reverse side of the page]

11-15-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15278

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First GRACE	Middle H.	Last SPEICHER	2a. DATE OF DEATH NOVEMBER 29, 1968		P.M. 20. HOUR 3:40		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7-28-02		6. AGE (In years lost day) 66 YRS.		IF UNDER 1 YEAR MONTHS OAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of life. If retired, state occupation if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY GARRETT		13c. CITY OR TOWN GRANTSVILLE		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER	
14. FATHER'S NAME		First CHRIST	Middle HERSHBERGER	Last IDA		15. MOTHER'S MAIDEN NAME		First M.	Middle YUTZY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-38-5960		17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease 342x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3 wks 3 wks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 350x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1968 to Nov. 2, 1968 , that (I) (we) lost saw the deceased alive on Nov. 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Clay Durrett DEGREE M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR						22c. DATE SIGNED 11/3/68			
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT						22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/4/68		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.			
24. FUNERAL DIRECTOR Kath J. Newman				ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

12500

STATE OF OHIO

1934

NOVEMBER 23 1934 2:40 P.M.

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ALLIANCE

U. S. A.

CUMBERLAND COUNTY HOSPITAL, HOSIERSVILLE

HARLAND GARRETT GRANVILLE

CHRIST MEMBERSHIP INDA YUTY

WE HILL HOSPITAL, CUM. CO.

DR. CLAY DUBRETT CUMBERLAND, MO.

NOV 8 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last DANIEL J. STAKEM					2a. DATE OF DEATH Month Day Year 11 26 68			2b. HOUR A 1:20		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 06-06-90			6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BARBER		12b. KIND OF BUSINESS OR INDUSTRY BARBER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN LONA CONING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 25 E. MAIN STREET	
14. FATHER'S NAME First Middle Last PATRICK STAKEM				15. MOTHER'S MAIDEN NAME First Middle Last (CAVANAUGH) ESTHER STAKEM						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) YES				16b. SOCIAL SECURITY NO. 220-52-9319		17. INFORMANT Address SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502				
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 AORTIC ANEURISM										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 1962, to 11-26, 1968, that (I) (we) last saw the deceased alive on 11-25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>L.M. Glick</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-26-68			
22d. PHYSICIAN'S NAME (Type) L.M. GLICK, MD.					22e. ADDRESS 912 SETON DR., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/29/1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park, Cumberland, MD.		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.				
24. FUNERAL DIRECTOR EICHHORN FUNERAL HOME, 8 E. MAIN ST., LONA CONING, MD. 21539					25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

18581

STATEMENT OF DEATH

18581

DATE	TIME	NAME	SEX	AGE	ETHNICITY	PLACE OF BIRTH	DATE OF BIRTH	PLACE OF DEATH	DATE OF DEATH	TIME OF DEATH	CAUSE OF DEATH	PLACE OF BURIAL	DATE OF BURIAL	TIME OF BURIAL	NAME OF FUNERAL HOME	ADDRESS OF FUNERAL HOME	PHONE OF FUNERAL HOME	NAME OF MINISTER	ADDRESS OF MINISTER	PHONE OF MINISTER	NAME OF CLERGY	ADDRESS OF CLERGY	PHONE OF CLERGY
11-20-30	11:00	DANIEL	M	70	WHITE	U.S.A.	06-08-30	ALLEGANY COUNTY,	06-08-30	11:00	SACRED HEART HOSPITAL	ALLEGANY COUNTY,	06-08-30	11:00	STANLEY	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET
		PATRICK	M	70	WHITE	U.S.A.	06-08-30	ALLEGANY COUNTY,	06-08-30	11:00	SACRED HEART HOSPITAL	ALLEGANY COUNTY,	06-08-30	11:00	STANLEY	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	22 E. MAIN STREET	

315 SETON DR., CUL., MD. 21502

L.I. CLICK, MD.

8 E. MAIN ST., LON CONING, MD. 21539
EICHEN FUNERAL HOME

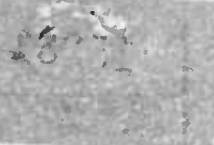
NOV 23 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) ROY			First C. Middle STALLINGS Last			20. DATE OF DEATH Month 11 Day 29 Year 68		21. HOUR 11:22 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-8-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Potomac Edison Employee		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5 WEBER STREET,	
14. FATHER'S NAME First LESLIE Middle IRVING Last STALLINGS			15. MOTHER'S MAIDEN NAME First SARAH Middle ELIZABETH Last COOK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-10-5163		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma of Brain 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621 Advanced Pulmonary Emphysema & Fibrosis ASHD										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June , 19 60 , to Nov 29 , 19 68 , that (I) (we) last saw the deceased alive on 11/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William P. James, MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12/1/68				
22d. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES						22e. ADDRESS 441 N. CENTRE ST. CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/2/68		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens LaVale		23d. LOCATION (City or Town) (County) (State) Allegany Maryland				
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service Cumberland, Md						25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE William J. Judge		



ROY

C.

STALLINGS

11

20

11:22

MALE

WHITE

048-1095

13

PERMA.

U. S. A.

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

MARYLAND

ALLEGANY CUMBERLAND

2 REEVE STREET,

BOY

STALLINGS

1095

MEMORIAL HOSPITAL-CUMBERLAND, MD.

DR. WILLIAM P. JAMES

441 N. CENTRE ST., CUMBERLAND, MD.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15288

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15293

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
JAMES A. STOKES						Month Day Year			PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	3-6-08	60 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			5:30 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF INDUSTRY		
Cumberland			Memorial Hospital			Curing Room			Pharmacist Kelly Springfield		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Allegany			Flintstone			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
James W Stokes			Hattie Mae Stokes			No			214-05-9636		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Mrs. Margaret A. Stokes, Star Route, Flintstone, Md.			PART I. DEATH WAS CAUSED BY:			5271			20. AUTOPSY?		
			IMMEDIATE CAUSE (a)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			DUE TO, OR AS A CONSEQUENCE OF								
			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
			COR PULMONALE								
			EMPHYSEMA, BRONCHIECTASIS								
			Years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY Month, Day, Year											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK											
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City or Town) (State)											
24. FUNERAL DIRECTOR											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

523

50-9-F

SI. 73

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
LENORA		C		TETER		NOVEMBER 12		1968		10:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		3-3-1883		85 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WHITMER, W. VA.		USA				ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND, MD.		MEMORIAL HOSPITAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.		ALLEGANY		CUMBERLAND				717 MEMORIAL AVE.,			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
GEORGE W.		WHITE		SUSAN		WHITE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4120 Falling from basis of</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>since 7-30-38</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Cholelithiasis & Cholecystitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7:30, 1938</u> , to <u>11:12, 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11-12-1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>W.F. Williams</u>		<u>11-13-68</u>		DR. W. F. WILLIAMS		122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Nov. 15, 1968		Davis Memorial Cemetery		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.				DATE NOV 18 1968		<u>Charles Judge</u>					

12345

LENDRA
FEMALE
WHITE
3-3-1882
NOVEMBER 12 1968
12345
ALLBANY
X
USA
WRITER, Y. VA.
CUMBERLAND, MD. MEMORIAL HOSPITAL
ALLBANY CUMBERLAND X VII MEMORIAL AVE.
GEORGE W. WHITE
SUSAN
WHITE
MEMORIAL HOSPITAL, CUMBERLAND, MD.

OR. W. A. WILLIAMS
123 S. CENTRE ST., CUMBERLAND, MD.

Nov. 12, 1968
D. A. Williams
CUMBERLAND, MD.
NOV 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

15284				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15295			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last ADA B THOMAS				2a. DATE OF DEATH NOVEMBER 17, 1968				2b. HOUR PM 3:55			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-8-87		6. AGE (In years lost birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER 503 MARYLAND AVE.,			
14. FATHER'S NAME First Middle Last STEVEN THOMAS		15. MOTHER'S MAIDEN NAME First Middle Last CLARA COPELAND									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 220-52-9930		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1533 IMMEDIATE CAUSE (a) Carcinomatosis due to Ca of Sigmoid DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1533 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis, Uremia											
19a. DATE OF OPERATION 10/27/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Sigmoid metastatic		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-27-68 , 19 68 , to 11-17 , 19 68 , that (I) (we) last saw the deceased alive, on 11-17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Andrew Staska		22c. DATE SIGNED 11-17-68		22d. PHYSICIAN'S NAME (Type) DR. V. DROSS		22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/20/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service		ADDRESS Cumberland, Md		25a. REC'D BY REGISTRAR Nov 20 1968		25b. REGISTRAR'S SIGNATURE					

NOVEMBER 13, 1958 3:35 PM
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 2-1-1950 MEMORIAL HOSPITAL, CUMBERLAND, MD.
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[Faint, illegible handwritten notes and signatures]

CUMBERLAND, MD. 02. V. Dress
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1-64
30M REV. 1-64

15283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15296

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Harry -- Turley			2a. DATE OF DEATH Month Day Year Nov. 30 1968		2b. HOUR 5:40 P.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/4/77		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Warp Knitting	12b. KIND OF BUSINESS OR INDUSTRY Fibres Corp.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Mt. Savage	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Church Hill	
14. FATHER'S NAME First Middle Last Enoch -- Turley		15. MOTHER'S MAIDEN NAME First Middle Last Eliza -- Cartwright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-1207	17. INFORMANT Address John Turley, Sr. Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) you					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH you
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April, 1967 , to Nov. 30, 1968 , that (I) (we) last saw the deceased alive on Nov. 30 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George M. Simons				22c. DATE SIGNED 12/1/68	
22d. PHYSICIAN'S NAME (Type) GEORGE M. SIMONS				22e. ADDRESS MEMORIAL HOSP, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/3/68		23c. NAME OF CEMETERY OR CREMATORY St. George Episcopal Cem.	
23d. LOCATION (City or Town) (County) (State) Mt. Savage, Allegany, Md.					
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 5 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First Eva		Middle Lena		Last Twigg		2a. DATE OF DEATH Month 18 Day 1968 Year		2b. HOUR 3 P M
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-25-93		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Elk Garden, Wva		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife & Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Restaurant				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 879 Patterson Ave.		
14. FATHER'S NAME First Edward		Middle P		Last Bailey		15. MOTHER'S MAIDEN NAME First Jeanette		Middle Cook		Last Cook
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-48-8945		17. INFORMANT Mr. O. Earl Twigg		Address 17 Long Ave. Bowling Greene		Cumb. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cecum & mitosis 1530 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1530 Diabetes Mellitus, Arteriosclerotic Heart Disease										
19a. DATE OF OPERATION Feb 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Cecum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 68 , to 18 Nov , 19 68 , that (I) (we) last saw the deceased alive on 16 Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A Stasko		M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-20-68
22d. PHYSICIAN'S NAME (Type) Andrew Stasko, M. D.		22e. ADDRESS 401 Decatur St. Cumberland, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/21/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumb. Md.		25a. DATE NOV 22 1968		25b. REGISTRAR'S SIGNATURE [Signature]				
Georges Funeral Home		202 Green St.								

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VR A15 (M)
30M REV. 11-68

15287										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15298									
1. DECEASED-NAME (Type or print) ^{First} Malinda ^{Middle} LINDA ^{Last} M. TWIGG										2a. DATE OF DEATH ^{Month} NOVEMBER ^{Day} 9, ^{Year} 1968										2b. HOUR ^{PM} 5:00									
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 10-24-1885			6. AGE (In years) (83) ^{YRS.}			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.																	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of year, if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY Own Home																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 707 Oldtown Road																	
14. FATHER'S NAME ^{First} PHILMORE ^{Middle} ^{Last} SHRYOCK			15. MOTHER'S MAIDEN NAME ^{First} SARAH ^{Middle} ^{Last} YAIDER																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.			Address																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Heart Failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1965</u> , to <u>Nov 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 9, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Dr. Blane Schindler</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>11/14/68</u>																							
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER			22e. ADDRESS CUMBERLAND, MD.																										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov. 13, 1968			23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR NOV 15 1968			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>																				

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ANNA			Middle C.			Last WELSH			2a. DATE OF DEATH Month 11 Day 22 Year 68			2b. HOUR 12:05M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 05-02-03			6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 24 PENNSYLVANIA AVENUE					
14. FATHER'S NAME First JOHN			Middle KIFER			Last KIKKER			15. MOTHER'S MAIDEN NAME First MARY			Middle TWIGG			Last KIKKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address MD. 21502			SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>1 mo.</u> <u>5 yrs.</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4200 Diabetes mellitus</u>																	
19a. DATE OF OPERATION <u>none</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>none</u>											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>none</u>			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 30, 1968</u> , to <u>Nov. 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>12:05 AM</u>																	
22b. SIGNATURE <u>J. P. Hallinan M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>11-23-68</u>					
22d. PHYSICIAN'S NAME (Type) J. P. HALLINAN, M.D.			22e. ADDRESS 140 BEDFORD ST., CUMB., MD. 21502														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Nov. 25, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>								
24. FUNERAL DIRECTOR ADDRESS SCARPELLI FUNERAL HOME, 108 VIRGINIA AVE., CUMB.			25a. REC'D BY REGISTRAR DATE NOV 29 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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J. P. MILLER, JR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15289											
15300											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
HARRIETT		J.		WELTON		NOVEMBER 15, 1968		5:15		A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		AUGUST 26, 1901		67 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
DAYTON, OHIO		U.S.A.				ALLEGANY COUNTY				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND,		MEMORIAL HOSPITAL, CUMBERLAND, MD.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		LUKE				301 FAIRVIEW STREET			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
CHARLES W.		WIERER						CHRISTINA		OSTENDORD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		234-62-4618		MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction, antero-septal,</i> 2509 DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension and A.S. cardiovascular disease</i> 10 years DUE TO, OR AS A CONSEQUENCE OF (c) <i>diabetes mellitus</i> 31 years 260X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1) Kimmel-Siegel Wilson Inten-capsillary glomerular nephritis 5 years</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1 July</i> , 1967, to <i>15 Nov.</i> , 1968, that (I) (we) last saw the deceased alive on <i>14 Nov.</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W.A. Van Ormer, M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>15 Nov. 68</i>					
22d. PHYSICIAN'S NAME (Type)		DR. W.A. VAN ORMER		22e. ADDRESS <i>122 SO. CENTRE STREET, CUMBERLAND, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		11/18/68		Philos		Westernport-Alle. Md.					
24. FUNERAL DIRECTOR <i>E.L. Boal</i>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE <i>NOV 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>					

1950

STATE OF NEW YORK

1950

IN SENATE, JANUARY 1, 1950.

REPORT OF THE COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

FOR THE YEAR ENDING DECEMBER 31, 1949.

ALBANY: JAMES B. LEE, STATE PRINTER, 1950.

301 FAIRVIEW STREET, ALBANY, N. Y.

COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

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COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

REPORT OF THE COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

FOR THE YEAR ENDING DECEMBER 31, 1949.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 2 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
Lawrence H. Whisner						Nov. 24, 1968			P M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	3/21/06	62 YRS.					November 29, 1968	5:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
West Virginia		U. S. A.				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			228 Harrison Street			None		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Allegany	Cumberland		228 Harrison St.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles N. Whisner			Hollie S. Henry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes: give war or dates of service)		17. INFORMANT ADDRESS				
No			493-24-9537		Glendine J. Whisner Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---
4109 CORONARY OCCLUSION CORONARY SCLEROSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		NOVEMBER 29, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		CUMBERLAND, MARYLAND	
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)
Burial		11/30/68	Allegany County Cemetery			Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Philip B. Wendt 121 Memorial Ave., Cumb., Md.						DEC 3 1968		Charles Judge	

10301

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10301

STATE OF
NEW YORK

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		10/15/1910		New York City	
Cause of Death		Disease		Organ		Manner of Death		Signature of Medical Examiner	
Heart Disease		Coronary Artery Sclerosis		Heart		Natural		J. H. Smith	
Time of Death		Place of Burial		Name of Burial Place		Name of Minister		Signature of Minister	
10:30 AM		St. Paul's Church		St. Paul's Church		Rev. J. H. Smith		J. H. Smith	
Signature of Medical Examiner		Signature of Minister		Signature of Burial Place		Signature of Minister		Signature of Burial Place	
J. H. Smith		J. H. Smith		St. Paul's Church		Rev. J. H. Smith		J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15292										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15302																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
ELIZABETH										WILLISON										WILKES										Month Day Year										NOV. 18, 1968										6:00 P.M.									
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										7. IF UNDER 1 YEAR MONTHS										8. IF UNDER 24 HRS. HOURS MIN									
FEMALE										WHITE										SEPT. 7, 1899										69 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
MARYLAND										U.S.A.																				ALLEGANY																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
FROSTBURG										MINERS HOSPITAL										TELEPHONE OPER.										C & P TEL.																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										FROSTBURG																				33 S. WATER STREET																			
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																													
BENJAMIN										WILKES										EVA										SHAFFER																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										FROSTBURG, MD. 21532																													
NO										N.A.										212-10-0180										MISS BESSIE WILKES, 33 S. WATER ST.,																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4109										DUE TO, OR AS A CONSEQUENCE OF										ACUTE MYOCARDIAL INFARCTION																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201										(b)										ARTERIOSCLEROTIC HEART DISEASE										10 days																													
										DUE TO, OR AS A CONSEQUENCE OF										(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										DIABETES MELLITUS																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1968, to Nov 18, 1968, that (I) (we) last saw the deceased alive on Nov. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										G. Paige Strong, M.D.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED Nov. 19, 1968																													
22d. PHYSICIAN'S NAME (Type)										A. PAIGE STRONG, M.D.										22e. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.										21532																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										11/21/68										FROSTBURG MEM. PARK										FROSTBURG, MARYLAND																													
24. FUNERAL DIRECTOR										M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG										25a. REC'D. BY REGISTRAR NOV 25 1968										25b. REGISTRAR'S SIGNATURE																													

1952

STATE OF OHIO

1952

Arteriosclerotic Heart Disease
Acute Myocardial Infarction

1949

Diabetes Mellitus

X

Nov 18 68 Nov 19 68 Nov 20 68

Chase, J. D.

X

Nov 19 68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15292

CERTIFICATE OF DEATH

15303

1. DECEASED NAME (Type or print) Edward BABY Donald BOY (B) WILSON			2a. DATE OF DEATH Month 11 Day 7 Year 68			2b. HOUR 7:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH NOV. 7, 1968		6. AGE (In years last birthday) YRS. MONTHS DAYS 5 4 0	
7a. BIRTHPLACE (State or foreign country) CUMBERLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 216 DECATUR ST.,							
14. FATHER'S NAME First Middle Last DONALD WILSON			15. MOTHER'S MAIDEN NAME First Middle Last JOANN BENNETT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 7761 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyaline membrane disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity (32 wks gestation)</u> 5-40 5-40							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 773.5							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-7</u> , 19 <u>68</u> , to <u>11-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert J. Dawson</i>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) DR. ROBERT J. DAWSON		22e. ADDRESS 500 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10388

UNITED STATES

WILSON

NOV 7 1963

WHITE

CUMBERLAND, N. S. A.

CUMBERLAND

MEMORIAL HOSPITAL

NOV 7 1963

ALLEGANY COUNTY

NOV 7 1963

WILSON

MEMORIAL HOSPITAL - CUMBERLAND, MD.

NOV 7 1963

DR. ROBERT A. DAVIS

NOV 9 1963

NOV 11 1963

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			2b. HOUR
WILLIAM WAYNE WOLFE Sr.						Month Day Year			4:45p M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	Oct. 16, 1921	47 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	4:45p M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		U. S.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			SACRED HOSPITAL--DOA			Parts Mgr.			Garage
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
W, Va			Wood		Parkersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2906 28th Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John T. Wolfe			Viola W. Bean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes			1940 to 1961		Karen P. Wolfe, Parkersburg, W, Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									SUDDEN
IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		HOUR A.M. P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 4, 1968		Arlington National Cem.		Arlington Va.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James F. Scarpell			DEC 5 1968			John Charles Judge			

DATE
1944-01-11

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WASH. STATE DEPT. OF AGRICULTURE
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
S. MARIE WRATCHFORD						11 Month 2 Day 68 Year			7:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE		WHITE		6 29 96			72 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign counted)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
WEST VIRGINIA		USA					ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give exact address)			12a. USUAL OCCUPATION (Kind of work done during life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
W. VA.						MOOREFIELD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	BOX 131
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
ABNER HOSE			LAURA POPE HOSE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			214 22 0967		SACRED HEART HOSPITAL 900 SETON DRIVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary Infarct.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/1/68</i> , to <i>11/2/68</i> , that (I) (we) last saw the deceased alive on <i>11/2/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i> M.D. DEGREE								22c. DATE SIGNED <i>11/4/68</i>	
22d. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN				22e. ADDRESS 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Olivet</i>			23d. LOCATION (City or Town) (County) (State) <i>Moorefield Hardy Md</i>		
24. FUNERAL DIRECTOR <i>Edward B. Orush</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 8 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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ALLEGANY

USA

WEST VIRGINIA

THUNDERBOLT

SACRED HEART HOSPITAL

CUNDELLAND

BOX 101

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MORRISFIELD

W. VA.

HOSE

ROUND ROBE

HOSE

HOSE

CUNDELLAND, WYOMING
SACRED HEART HOSPITAL
CCC SET IN DRIVE

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NO

LEAVE, LAYLAND, 21500
1000 NATIONAL HIGHWAY

DR. J. A. PACE

NOV 8 1968